

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, -301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First <i>MARGARET</i> Middle <i>T.</i> Last <i>BAIN</i>						2a. DATE OF DEATH Month <i>June</i> Day <i>5</i> Year <i>1968</i>			2b. HOUR <i>1:25</i> AM			
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>October 6, 1907</i>			6. AGE (In years lost birthday) <i>60</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Kessamine Co. Ky.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.						
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington Co. Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>House wife</i>			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Penna</i> <i>908 Eastland Rd.</i>			13b. COUNTY <i>Franklin</i>		13c. CITY OR TOWN <i>Waynesboro, Pa.</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>908 Eastland Rd.</i>			
14. FATHER'S NAME First <i>Oliver</i> Middle <i>F.</i> Last <i>Troutman</i>				15. MOTHER'S MAIDEN NAME First <i>Amanda</i> Middle <i>F.</i> Last <i>Goode</i>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>no</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>257-07-0304</i>		17. INFORMANT Address <i>Pa.</i> <i>Warren L. Bain Jr. 908 Eastland Rd. Waynesboro</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>endotoxic shock</i> <i>5901</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>acute left pyelonephritis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hours.</i> <i>48 hours</i>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>600.0 diabetes mellitus, urethral stricture</i>												
19a. DATE OF OPERATION <i>none</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>autopsy not completed</i>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <i>May 28, 1968</i> , to <i>June 4, 1968</i> , that (I) (we) last saw the deceased alive on <i>June 4, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <i>Joseph C. Crisp M.D.</i>				DEGREE <i>M.D.</i>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-5-68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Joseph C. Crisp, M.D.</i>				22e. ADDRESS <i>Hagerstown Ind.</i>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/10/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Lexington Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Lexington Jefferson Co. Ky.</i>						
24. FUNERAL DIRECTOR <i>Walter Z. Grove</i>				ADDRESS <i>Waynesboro, Penna.</i>		25a. REC'D BY REGISTRAR <i>JUN 7 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Richard J. Young</i>				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
HAROLD EDWARD BEAN						ESTIMATED <input type="checkbox"/> Month Day Year			11 AM
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	Dec 8 1923	44 YRS.			Month Day Year			11 AM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			Md.
Maryland		U.S.A.				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash County Hospital			Taxi Driver		Star Cab Co	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER	
Maryland			Washington Hagerstown					622 W. Washington St	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Archie S. Bean Sr				Susan E. Kretzer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
No			217-12-2199			Mrs Susan E. Bean 431 W. Church St			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 Coronary occlusion								sudden	
DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic coronary artery disease								yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4201									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
			19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Howard N. Weeks, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		
EXAMINER'S NAME (Type)		580 Northern Avenue Hagerstown, Maryland 21740			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		6/4/68		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/8/68		Rose Hill Cemetery		Hagerstown Wash Co Md.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Andrew K. Coffman				Funeral Home Inc		DATE JUN 7 1968			

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June 3 1963

HANDLING: HOWARD BEAN

June 3 1963

File: Phil Dec 8 1963

Received U.S.A. x Washington

Hagerstown Wash County N Capital Taxi Driver Over Cal

Washington Hagerstown xx 302 W. Washington St

Archie E. Bean Sr Susan E. Krister

217-12-2129 Mr Susan E. Bean 431 W. Church St Hagerstown Md

Archie E. Bean Sr Susan E. Krister Hagerstown Md. 217-12-2129

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First HARVEY			Middle MICKLEY			Last BELL			2a. DATE OF DEATH Month 6 Day 11 Year 68			2b. HOUR 10 P.M.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH January 9, 1886			6. AGE (In years lost birthday) 82 YRS.			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			IF UNDER 24 HRS. MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store			12b. KIND OF BUSINESS OR INDUSTRY Grocery								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Williamsport			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 128 Bower Ave.					
14. FATHER'S NAME First Middle Last William H. Bell			15. MOTHER'S MAIDEN NAME First Middle Last Sarah Hoffman			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No						16b. SOCIAL SECURITY NO. 220-09-7863			17. INFORMANT Mrs. Ora A. Bell		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 left coronary artery with propagation into												several days					
DUE TO, OR AS A CONSEQUENCE OF anterior descending branch.																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis of aorta and coronary arteries,												several years					
DUE TO, OR AS A CONSEQUENCE OF moderately advanced.																	
Myocardial infarction, probably early, 1st ventricle,																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) 4201																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 6/6/68, 19__, to 6/11/68, 19__, that (I) (we) last saw the deceased alive on 6/11/68, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE [Signature]			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6/13-68								
22d. PHYSICIAN'S NAME (Type) E. W. Ditto, Jr., M.D.			22e. ADDRESS 215 W. Washington St., Hagerstown, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 14, '68			23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Williamsport, Wash. Md.								
24. FUNERAL DIRECTOR ADDRESS Albert L. Leaf 2110 Lex. Ave. Hagerstown, Maryland			25a. REC'D BY REGISTRAR DATE JUN 17 1968			25b. REGISTRAR'S SIGNATURE [Signature]											



[Faint, mostly illegible text, possibly a list or report. Some words like "ITEM", "DATE", and "DESCRIPTION" are faintly visible.]  
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 ITEM 2. [illegible]  
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VS A-17-1  
30M REV. 11-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First <b>AGNES</b>	Middle <b>MAY</b>	Last <b>BENDER</b>	2a. DATE OF DEATH June Month 20, Day 1968		2b. HOUR M		
3. SEX <b>Female</b>	4. RACE <b>White</b>		5. DATE OF BIRTH <b>May 26, 1885</b>		6. AGE (In years last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>3 24</b>	IF UNDER 24 HRS. HOURS MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Sharpsburg</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Chaplin Street</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Sharpsburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>West Chaplin Street</b>	
14. FATHER'S NAME First Middle Last <b>William Henry Stull</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Emma Kate Kidwell</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <b>220-54-4735</b>		17. INFORMANT <b>Chaplin Street</b> <b>Miss Betsy Bender Sharpsburg, Maryland</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency</u> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary sclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>6 mo.</b> <b>3+ years</b> <b>3+ years</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>Oct 1967</u> , to <u>June 1968</u> , that (I) (we) last saw the deceased alive on <u>June 20, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Halvard Wanger</b>				DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/20/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Halvard Wanger M.D.</b>				22e. ADDRESS <b>Shepherdstown, W. Va.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 23, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Sharpsburg, Washington, Md.</b>			
24. FUNERAL DIRECTOR <b>Albert L. Leaf</b>				ADDRESS <b>Williamsport, Maryland.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

02030





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>Gladys Ruth Bergstresser</b>						2a. DATE OF DEATH Month <b>June</b> , Day <b>1</b> , Year <b>1968</b>		2b. HOUR <b>6:40</b> AM	
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Nov. 28, 1904</b>		6. AGE (In years last birthday) <b>63</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>none</b>		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <b>Penna.</b>		13b. COUNTY <b>Fulton Co.</b>		13c. CITY OR TOWN <b>Waterfall</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>William G. Bergstresser</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Josephine Bergstresser</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b>		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>174-20-3636</b>		17. INFORMANT Address <b>Paul Bergstresser, Waterfall, Pa.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> <b>431.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>331X Hypertension</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/26</b> , 19 <b>68</b> , to <b>6/1</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>5/21/68</b> , 19 <b></b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Wm. O. Rexrode</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/1/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>William O. Rexrode M. D.</b>				22e. ADDRESS <b>145 South Prospect Street</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6-4-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Bethel Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Wells Township, Ful. Co. Pa.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			

10020

1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 2679, 2680, 26

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN b. <u>1 DAY</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		d. STREET ADDRESS <u>State Line</u>	
3. NAME OF DECEASED (Type or print) <u>MASON C. BINKLEY</u>		4. DATE OF DEATH <u>June 24 1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/1901</u>
9. AGE (in years last birthday) <u>66</u>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during prior 12 months, or if retired, state (retired)) <u>Retired Post MASTER</u>		12. BIRTHPLACE (County & State, or foreign country) <u>State Line, Pa.</u>	
13. FATHER'S NAME <u>Charles N. Binkley</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Brumbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>185-01-2382</u>	
17. INFORMANT <u>Mary Binkley</u>		Address <u>State Line Pa.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat White <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 23</u> , 19 <u>68</u> , to <u>June 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 24</u> 19 <u>68</u> , and that death occurred at <u>1 P.</u> M. from causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		22b. DATE SIGNED <u>6/25/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22d. ADDRESS <u>214 N. Pot. St. Hagerstown, Md</u>	
23a. BURIAL, CREMATION, or other disposition <u>Burial</u>	23b. DATE THEREOF <u>6/27/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>State Line Pa.</u>
24. FUNERAL DIRECTOR <u>A. G. Munnich - Greencastle Pa.</u>		25a. REC'D BY REGISTRAR <u>June 27 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

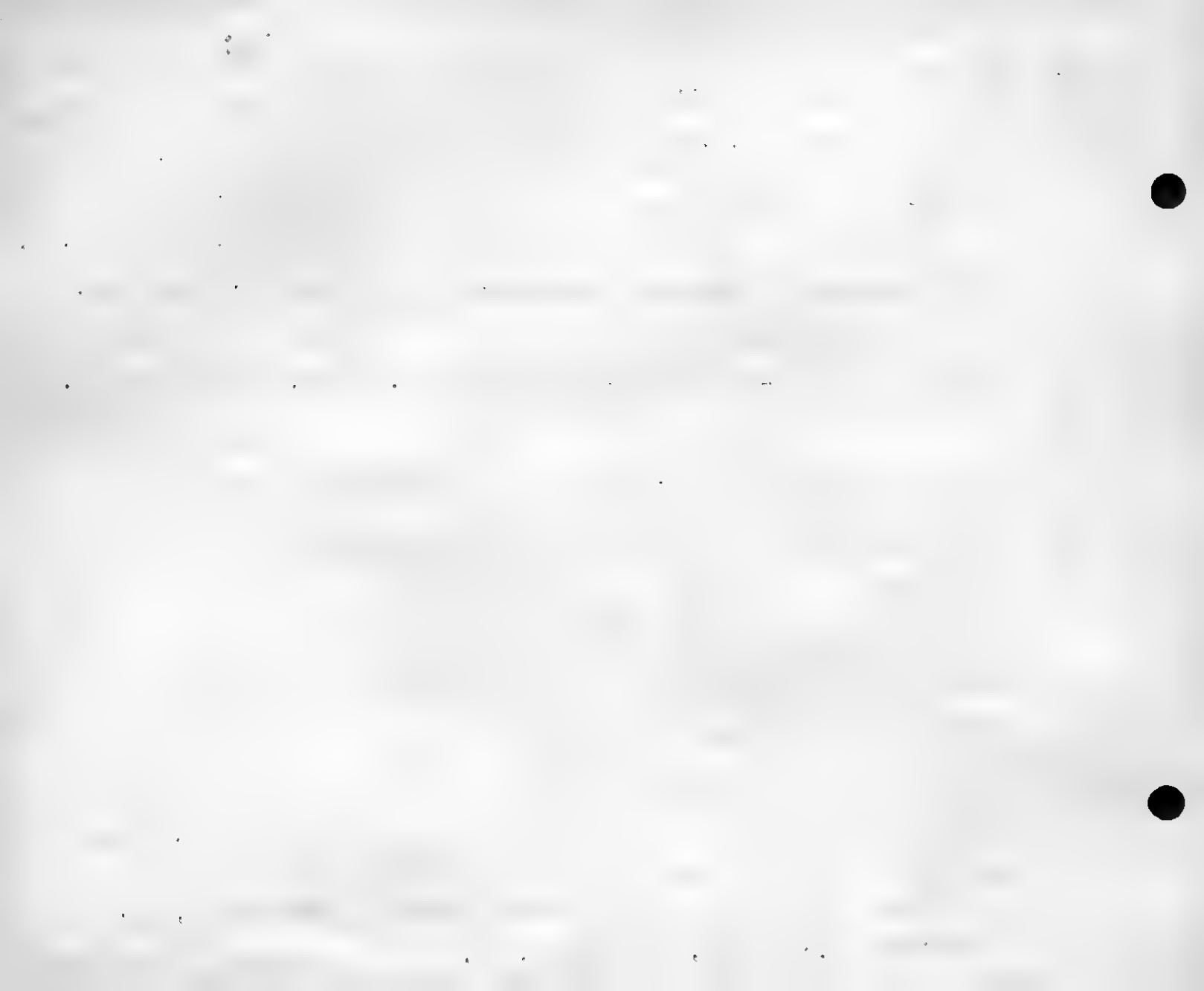
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 3 should be forwarded to the Chief Medical Examiner's Office along with form 100-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 1966

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Harold Wilbur Bloom						ESTIMATED DATE 6/8/68			1968		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			2d. HOUR
male	white	10-8-41	26 YRS	MONTHS	DAYS	HOURS	MIN.	Month 6/ Day 8/ Year 1968			1:30 M.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Maryland			USA						Washington		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Paradise Church Rd. Rt. 6			clerk typist			truck mfg.		
13a. USUA. RESIDENCE (Where deceased lived, if admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
Maryland			Washington			Hagerstown			200 Robinwood Dr.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Wilbur Norman Bloom			Blanche Rebecca Brown								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or Unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
yes			1-64 8-64			220-40-2431			Wilbur N. Bloom, Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:										Minutes	
IMMEDIATE CAUSE (a) Cardiac tamponade											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) Penetrating stab wounds of chest											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>				21b. TIME OF INJURY Month, Day Year				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
CAUSE OF DEATH				HOUR A.M. P.M. 19							
21d. INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
Howard N. Weeks, M.D.								6/10/68			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				Address (Street, City, Town, or County)			
580 Northern Ave.				Hagerstown, Md.							
23a. BURIAL CREMATION				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				6-11-68				Smithsburg Cemetery			
23d. LOCATION (City or Town)				23e. COUNTY				23f. STATE			
Smithsburg, Md.											
24. FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR			
Minnich Funeral Home, Smithsburg, Md.								DATE JUN 13 1968			
								25b. REGISTRAR'S SIGNATURE			
								J. Charles Judge			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
			Meda	Belle	Bowers	June 7 1968		8:30 P.M.	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR	
Female	White		March 20, 1894			74 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Waynesboro, Pa.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown		Garlock Nursing Home			Housewife		Own Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown				629 Hayes Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
			Joseph		Coffman				Sarah
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
No				219-54-1045		Mr. Robt. K. Bowers 21 Cedar Crest Ave. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic Heart Disease</u>									6 yrs
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic cystitis</u>									2 yrs
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 7/21/65, 19, to 6/7/68, that (I) (we) last saw the deceased alive on 6/6/68 and that in (my) (our) opinion death occurred on the date one hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Donald E. Martin</u>					22c. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22d. DATE SIGNED <u>6/10/68</u>		
22e. PHYSICIAN'S NAME (Type) Donald E. Martin, M.D.					22f. ADDRESS 363 S. Cleveland Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 11, 1968		Antietam Natl. Cemetery		Sharpsburg-Washington-Md.			
24. FUNERAL DIRECTOR <u>Wm. C. Horst</u>					ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REGISTRAR <u>JUN 12 1968</u>		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

7-201-40-815

— 3 —

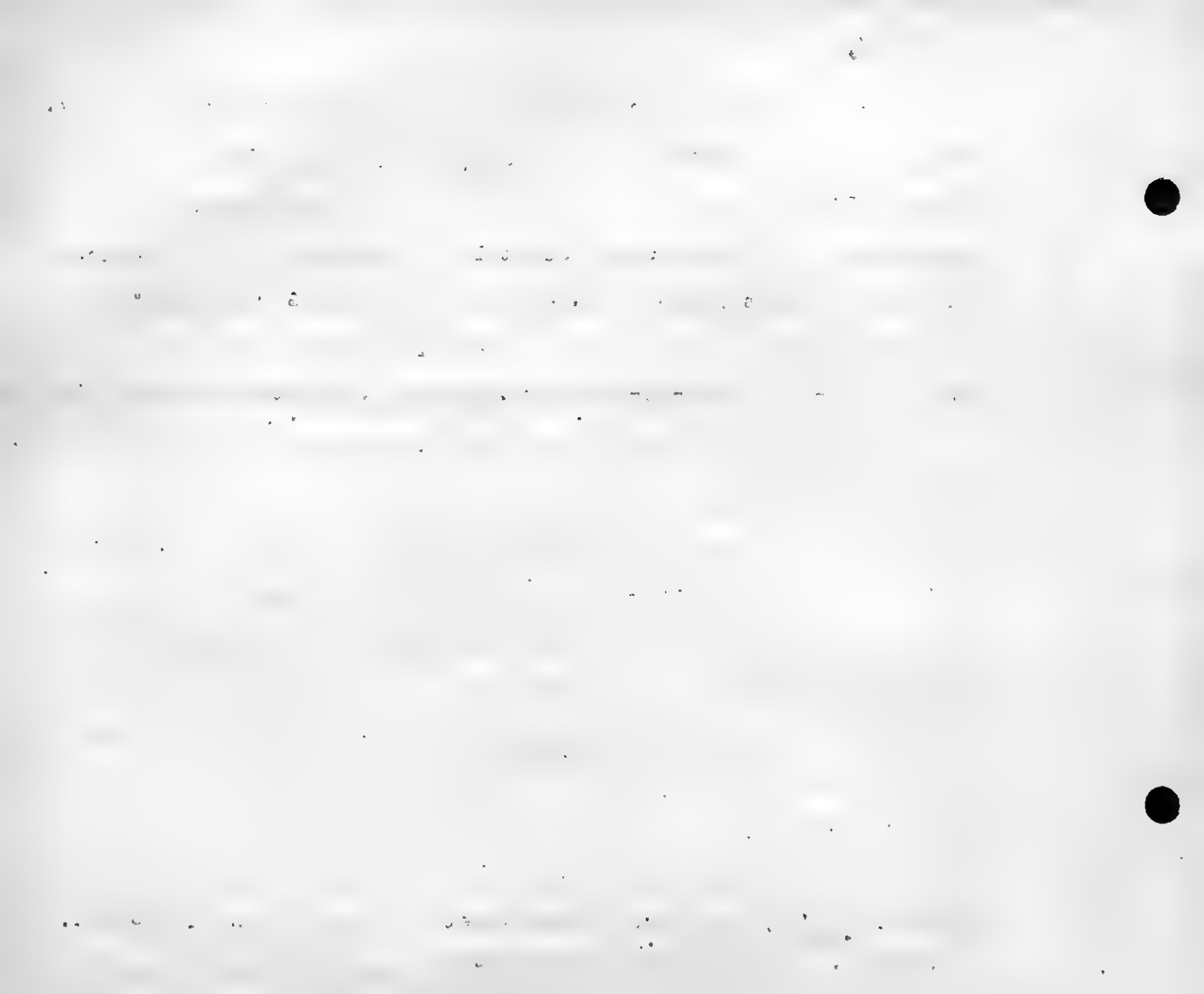
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filled in with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VS 12-1-68  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>VAL SMITH BRISTOW Sr</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>7.20 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>July 17 1917</b>		6. AGE (In years last birthday) <b>50</b> YRS		7. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Baltimore City</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Merchant</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Retired</b>			
13a. USUAL RESIDENCE (Where deceased lived, if instit on: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1013 Oak Hill Ave</b>	
14. FATHER'S NAME First Middle Last <b>Floyd B Bristow</b>			15. MOTHER'S M.A.DEN NAME First Middle Last <b>Madeline Smith</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO <b>207-01-4009</b>		17. INFORMANT Address <b>Mrs Martha W. Bristow 1013 Oak Hill Ave</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>21 May 68</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <b>Hagerstown Md.</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Hypertensive Cardiovascular Disease - Arteriosclerotic changes</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 <b>63</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> hot while <input type="checkbox"/> at work		21e. PLACE OF INJURY (OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8 Dec 63</b> to <b>13 June 1968</b> , that (I) (we) last saw the deceased alive on <b>13 June 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard T. Binford</b>				22c. DATE SIGNED <b>14 June 68</b>		22d. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22e. PHYSICIAN'S NAME (Type) <b>Richard T. Binford, M. D.</b>				22f. ADDRESS <b>1135 Potomac Avenue Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Wash Co Md.</b>			
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>				24a. REC'D BY REGISTRAR <b>JUN 20 1968</b>		24b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



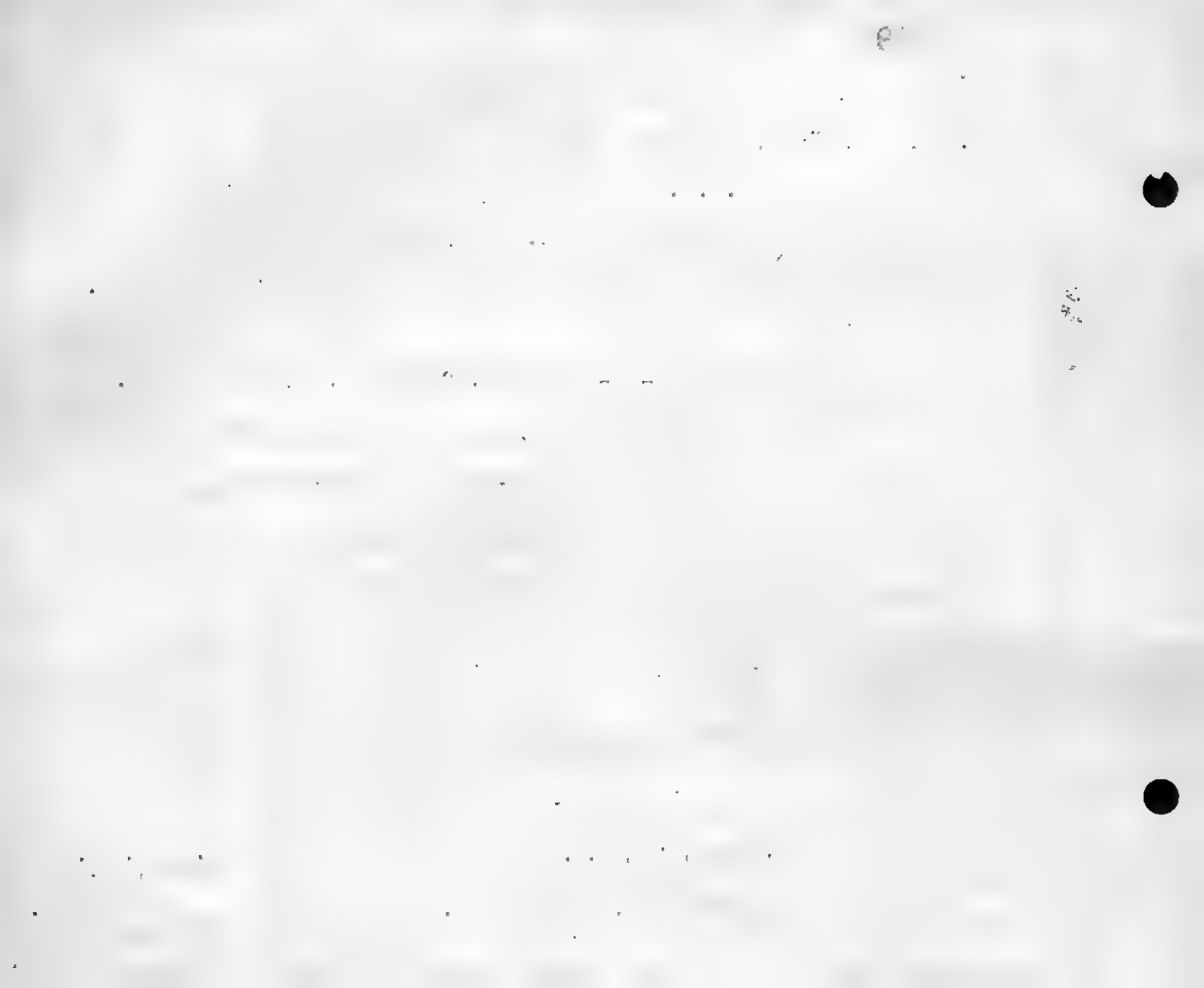


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PW-555. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or Print)			First <b>ANNIE</b>			Middle <b>MARIAH</b>			Last <b>BROWN</b>		
2a DATE KNOWN OF DEATH			ESTIMATED <input checked="" type="checkbox"/> Month Day Year <b>6 15 1968</b>			2b HOUR <b>1 P M</b>					
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>12/2/1881</b>		6 AGE (In years) <b>86</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <b>WASHINGTON</b>		
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give place of death) <b>WASHINGTON CO. HOSPITAL</b>			12a USUAL OCCUPATION (Kind of work done during normal hours, if retired) <b>HOUSEWIFE</b>			12b KIND OF BUSINESS OR INDUSTRY <b>HOME</b>		
13a USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) <b>MARYLAND</b>			13b COUNTY <b>WASHINGTON</b>			13c CITY OR TOWN <b>HAGERSTOWN</b>			13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
14 FATHER'S NAME First <b>HENRY</b>			Middle <b>BIXLER</b>			Last <b>SEVILLA</b>			15 MOTHER'S MAIDEN NAME First <b>GARVICK</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16b SOCIAL SECURITY NO <b>220-09-7862</b>			17 INFORMANT <b>MRS. BESSIS V. GARMAN</b>			ADDRESS <b>HAGERSTOWN MD.</b>		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Arteriosclerotic heart disease</b> <b>4127</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Advanced generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>25 yrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>4200 Fracture lt. femur</b>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day Year HOUR A.M. <b>9:45 AM 6-6 1968</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fell At Home</b>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc) <b>Home</b>				21f LOCATION Street or RFD No City or Town County State <b>714 Maryland R. Hagerstown Wash Md</b>			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Edward W. Ditto, III, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>6-17-68</b>			
EXAMINER'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				ADDRESS (Street, city, town, or county) <b>217 W. Wash. St. Hagerstown, Md.</b>							
23a BURIAL, CREMATION, or other disposal (Specify) <b>BURIAL</b>			23b DATE <b>6/18/68</b>			23c NAME OF CEMETERY OR CREMATORY <b>MT. OLIVET CEM.</b>			23d LOCATION (City or town) (County) (State) <b>HANOVER PENNA.</b>		
24 FUNERAL DIRECTOR <b>W. J. Normant, Hagerstown Md.</b>						ADDRESS		25a REC'D BY REGISTRAR DATE <b>JUN 20 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH																									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH																									
1. DECEASED NAME (Type or Print)			First			Middle			Last			2a. DATE KNOWN OF DEATH			2b. HOUR A M										
Larry James Carbaugh												Month Day Year			6-6-68 19										
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		F UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN		2c. DATE PRONOUNCED DEAD			2d. HOUR A M										
male		white		2-23-39		29 YRS						Month Day Year			6 1968 2 37										
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH													
Maryland				USA								Washington													
10. CITY OR TOWN OF DEATH						11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)						12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)				12b. KIND OF BUSINESS OR INDUSTRY									
Hagerstown						Wash. Co. Hospital						clerk				auto dealer									
13a. USUAL RESIDENCE (Where deceased lived, if admission) STATE						13b. COUNTY						3c. CITY OR TOWN		3d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER									
Md.						Washington						Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1035 Concord St.									
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME																			
First Middle Last						First Middle Last																			
James B. Carbaugh						Charlotte Pangle																			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)						16b. SOCIAL SECURITY NO						17. INFORMANT						ADDRESS							
yes						1936-1938 214-34-7670						Doris W. Carbaugh, Hagerstown, Md.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Gun shot wound head</u>														1-2 hrs.											
755 X DUE TO, OR AS A CONSEQUENCE OF																									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																									
(b) DUE TO, OR AS A CONSEQUENCE OF																									
(c)																									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)																									
716 X																									
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH						21b. TIME OF INJURY Month, Day, Year HOUR AM PM						21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)													
						6-6-68 12 PM						Self inflicted gunshot wound Head													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK						21e. PLACE OF INJURY (At home farm street, factory office building, etc)						21f. LOCATION Street or R.F.D. No City or Town County State													
						Home						1035 Concord St - Hagerstown Wash Md													
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																									
ACTUAL SIGNATURE						CHIEF MEDICAL EXAMINER <input type="checkbox"/>						22b. DATE SIGNED													
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>						6-7-68													
Edward W. Ditto, III, M.D.						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>						217 W. Wash. St. Hagerstown, Md.													
23a. BURIAL, CREMATION, REMOVAL (Specify)						23b. DATE						23c. NAME OF CEMETERY OR CREMATORY						23d. LOCATION (City or Town) (County) (State)							
burial						6-8-68						Rose Hill Cemetery						Hagerstown, Md.							
24. FUNERAL DIRECTOR												ADDRESS						25a. RECD BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home, Hagerstown, Md.																		DATE JUN 10 1968				Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

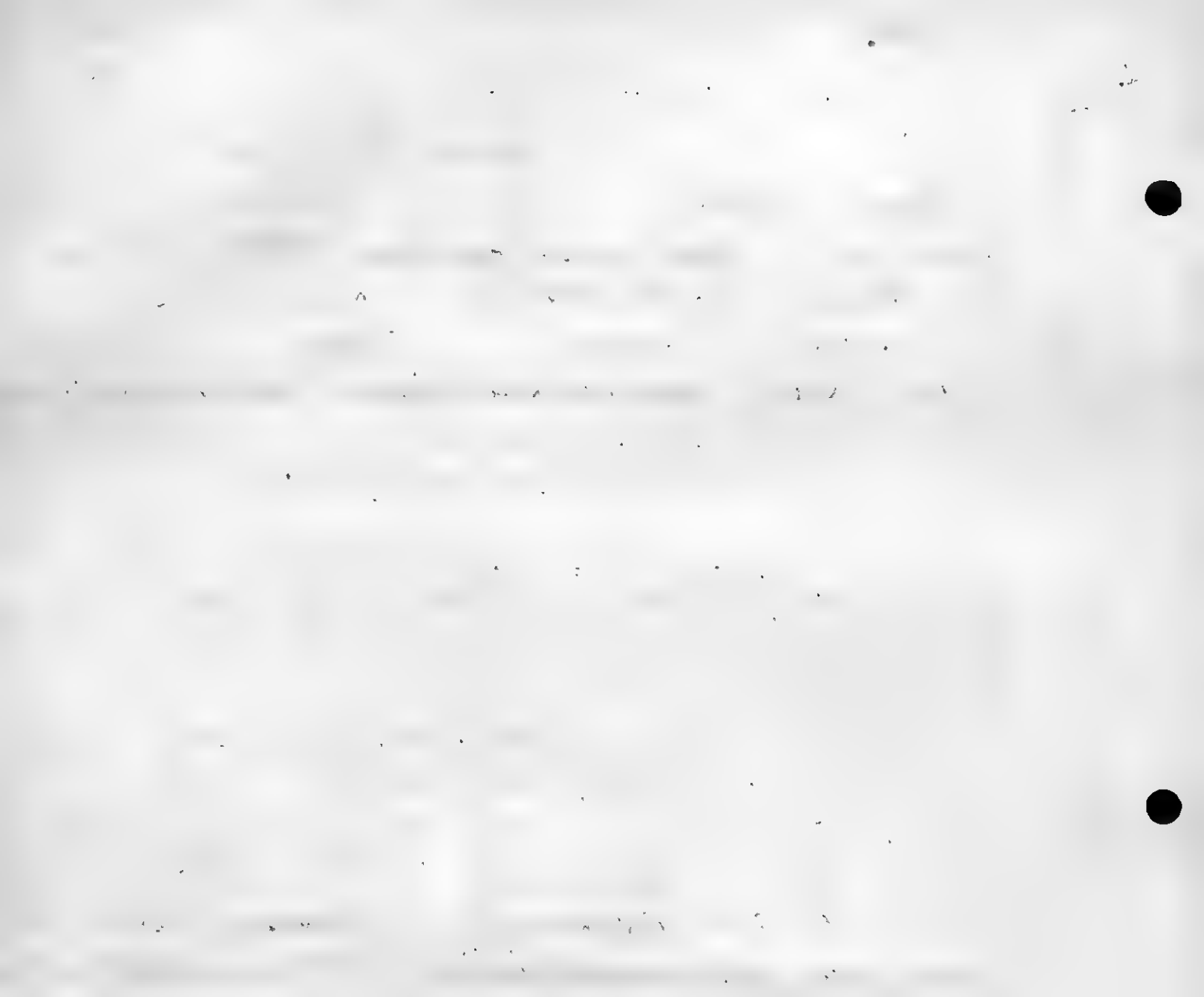
1

25063

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <sup>First</sup> RUSSELL <sup>Middle</sup> FRANKLIN <sup>Last</sup> CASSELL				2a. DATE OF DEATH 6 Month 24 Day 1968 Year 68		2b. HOUR 4:30 P.M.	
3 SEX M		4. RACE W		5. DATE OF BIRTH 2-12-1896		6. AGE (in years last birthday) 72 YRS	
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, or last occupation if retired) Penna State Police		12b. KIND OF BUSINESS OR INDUSTRY Police	
13a. USUAL RESIDENCE (Where deceased lived, if institution, residence before admission) STATE Penn.		13b. COUNTY Franklin		13c. CITY OR TOWN Fayetteville		13d. INSIDE CITY, Y.N.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME <sup>First</sup> John <sup>Middle</sup> <sup>Last</sup> Cassel		15. MOTHER'S MAIDEN NAME <sup>First</sup> Emma <sup>Middle</sup> <sup>Last</sup> Mortz					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service) WWI		16b. SOCIAL SECURITY NO 210-26-6269		17. INFORMANT Lillie M. Cassel		Address R2 Fayetteville, Penn.	
18. CAUSE OF DEATH (Enter on only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pelvic peritonitis 188X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Carcinoma of urinary bladder DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 1 yr.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) generalized arteriosclerosis							
19a. DATE OF OPERATION 3-20-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma bladder		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 20, 1968 to June 24, 1968, that (I) (we) last saw the deceased alive on June 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Joseph C. Crisp MD				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-25-68	
22d. PHYSICIAN'S NAME (Type) JOSEPH C. CRISP				22e. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-27-68		23c. NAME OF CEMETERY OR CREMATORY Norland Cemetery		23d. LOCATION (City or Town) (County) (State) Chambersburg Franklin Penn.	
24. FUNERAL DIRECTOR John O. Park				25a. REC'D BY REG STRAR DATE JUN 28 1968		25b. REG. STRAR'S SIGNATURE Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon copy. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) <b>Ethel Rae Mae Clayton</b>		First Middle Last		2a DATE OF DEATH <b>June 27, 1968</b>		2b HOUR <b>12:30 PM</b>	
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>May 22, 1904</b>		6 AGE (In years last birthday) <b>64</b>	
7a BIRTHPLACE (State or foreign country) <b>Job, W. Va.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>	
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>House Wife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>Maryland</b>		13b CITY OR TOWN <b>Smithsburg</b>		13c INSIDE CITY LIMITS? <b>YES</b>		13e STREET AND NUMBER <b>Smithsburg, Rt. 1</b>	
14 FATHER'S NAME <b>John W. Teter</b>		First Middle Last		15. MOTHER'S MAIDEN NAME <b>Ella F. Lambert</b>		First Middle Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b>		16b SOCIAL SECURITY NO <b>no</b>		17 INFORMANT Address <b>Mr. Royce Clayton, Cumberland, Md. - Son</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of uterus and metastases</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>1741</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>4-16-68</b> , 19 <b>68</b> , to <b>June 27, 1968</b> , that (I) (we) last saw the deceased alive on <b>6-22-68</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Dr. James F. Scarpelli</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-28-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Dr. James F. Scarpelli</b>				22e. ADDRESS <b>307 W. Preston St., Baltimore, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL <b>Buried</b>		23b. DATE <b>June 30, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>	
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL - 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

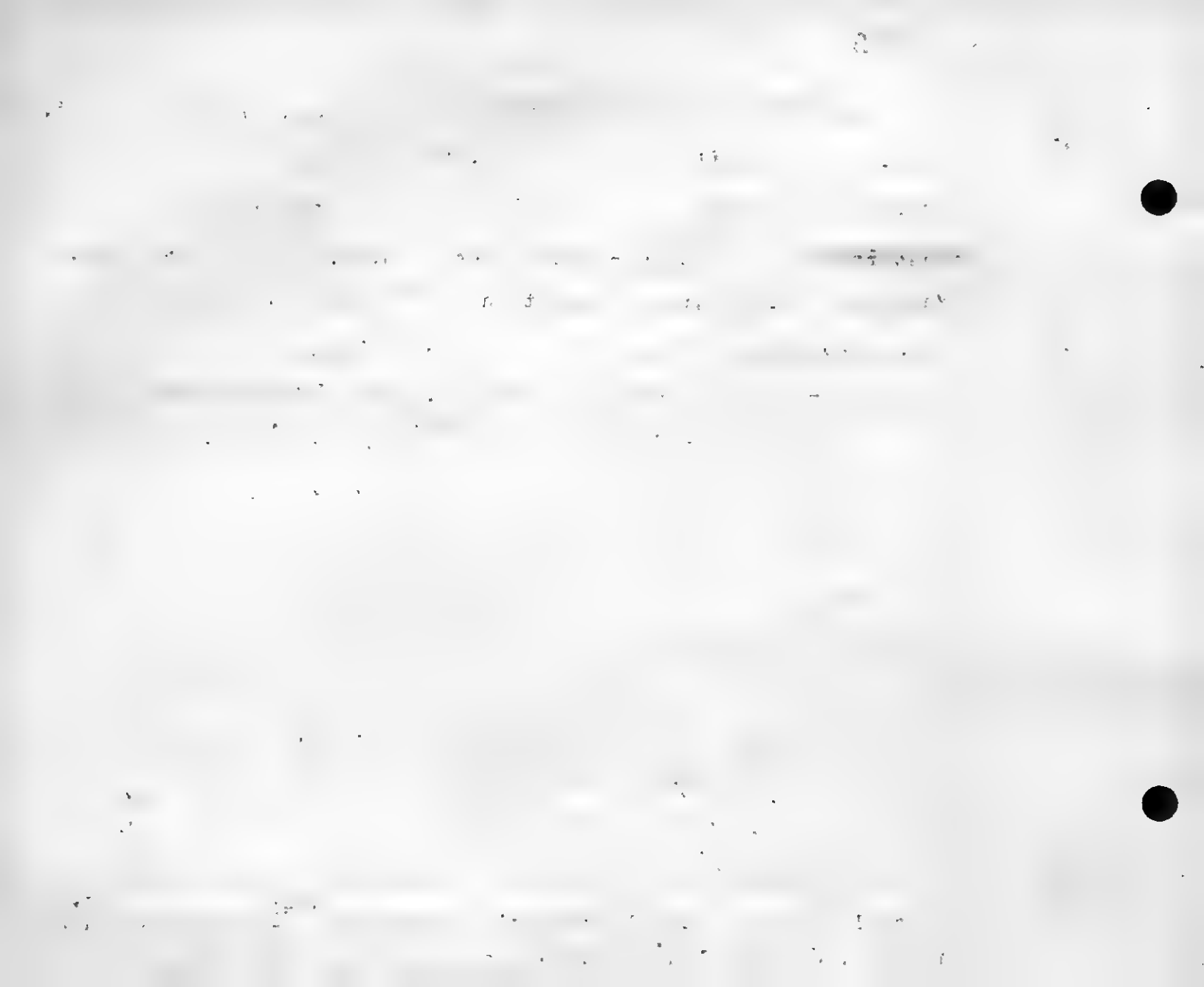
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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89065

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>GERTRUDE COLE-BLICKENSTAFF</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>7</b> Year <b>1968</b>			2b. HOUR <b>6.40</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 20 1874</b>		6. AGE (in years last birthday) <b>93</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			Md.		
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fahrney-Keedy Home</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution, give street address) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>1013 Corbett St</b>			
14. FATHER'S NAME First <b>Simon</b> Middle <b>Trumpower</b> Last <b>Repp</b>			15. MOTHER'S MAIDEN NAME First <b>Ruanna</b> Middle <b>Repp</b> Last <b>Repp</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown) <b>No</b>		(If yes give war or dates of service) <b>---</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Fred M. Cole 8 Marbern Road</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Enteroviral cardiac vasculature</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cerebral Haemorrhage</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>---</b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 yrs</b> <b>10 days</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>---</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (the hospital) attended the deceased from <b>May 5</b> , 19 <b>68</b> , to <b>June 7</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>June 6</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>G. W. Lelan M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/8/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>G. W. Lelan M.D.</b>		22e. ADDRESS <b>Boonsboro, Md.</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/9/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Little Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>near Clear Spring Wash Co</b>					
24. FUNERAL DIRECTOR <b>Andrew K. Coffman</b>		Hagerstown, Md. ADDRESS <b>Funeral Home Inc</b>		25a. REC'D BY REGISTRAR <b>JUN 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>					





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 shall be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) <b>IRENE B. COLLIER</b>						2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year <b>6-14 1968</b>		2b HOUR <b>12:15 PM</b>			
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>5/26/1914</b>		6 AGE (in years last birthday) <b>54</b> YRS		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a BIRTHPLACE (State or foreign country) <b>Penn.</b>			7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>		Md	
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital Hagerstown</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
13a USUAL RESIDENCE (Where deceased lived, if not in residence before death, give street address) <b>Penn.</b>				13b COUNTY <b>Franklin</b>		13c CITY OR TOWN <b>Greencastle</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>RR # 2</b>	
14 FATHER'S NAME <b>EVAN - Burkholder</b>						15 MOTHER'S MAIDEN NAME <b>Marietta - CATON</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown <input type="checkbox"/> )				16b SOCIAL SECURITY NO <b>220-10-3348</b>		17. INFORMANT <b>Harry C. Collier - Adress</b>				ADDRESS <b>Greencastle</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Aspiration gastric contents -</b>											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <b>Puncturing gunshot wound head - lateration</b>											
DUE TO, OR AS A CONSEQUENCE OF											
(c) <b>Frontal lobe &amp; Subdural Hematoma</b>										<b>18 hrs</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>976</b>											
19a. DATE OF OPERATION						19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year <b>6-13 1968</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18) <b>Self inflicted gunshot wound to head</b>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f LOCATION Street or R.F.D. No <b>RR # 2</b>		City or Town <b>Greencastle</b>		County <b>Franklin</b> State <b>Pa.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Edward W. Ditto</b> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>6-14-68</b>	
EXAMINER'S NAME (Type) <b>DR. EDWARD W. DITTO III</b>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6-14-68</b>		22d. CITY, TOWN, OR COUNTY <b>Greencastle, Pa.</b>	
23a BURIAL, CREMATION, REMAINS (Specify)		23b DATE <b>6/16/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill</b>				23d LOCATION (City or Town) <b>Greencastle, Pa.</b>		(County) <b>Franklin</b> (State) <b>Pa.</b>	
24. FUNERAL DIRECTOR <b>W. E. Hinnich - Greencastle</b>						ADDRESS <b>Greencastle</b>		25a RECD BY REGISTRAR DATE <b>JUN 17 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles J. J...</b>	



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

08072

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

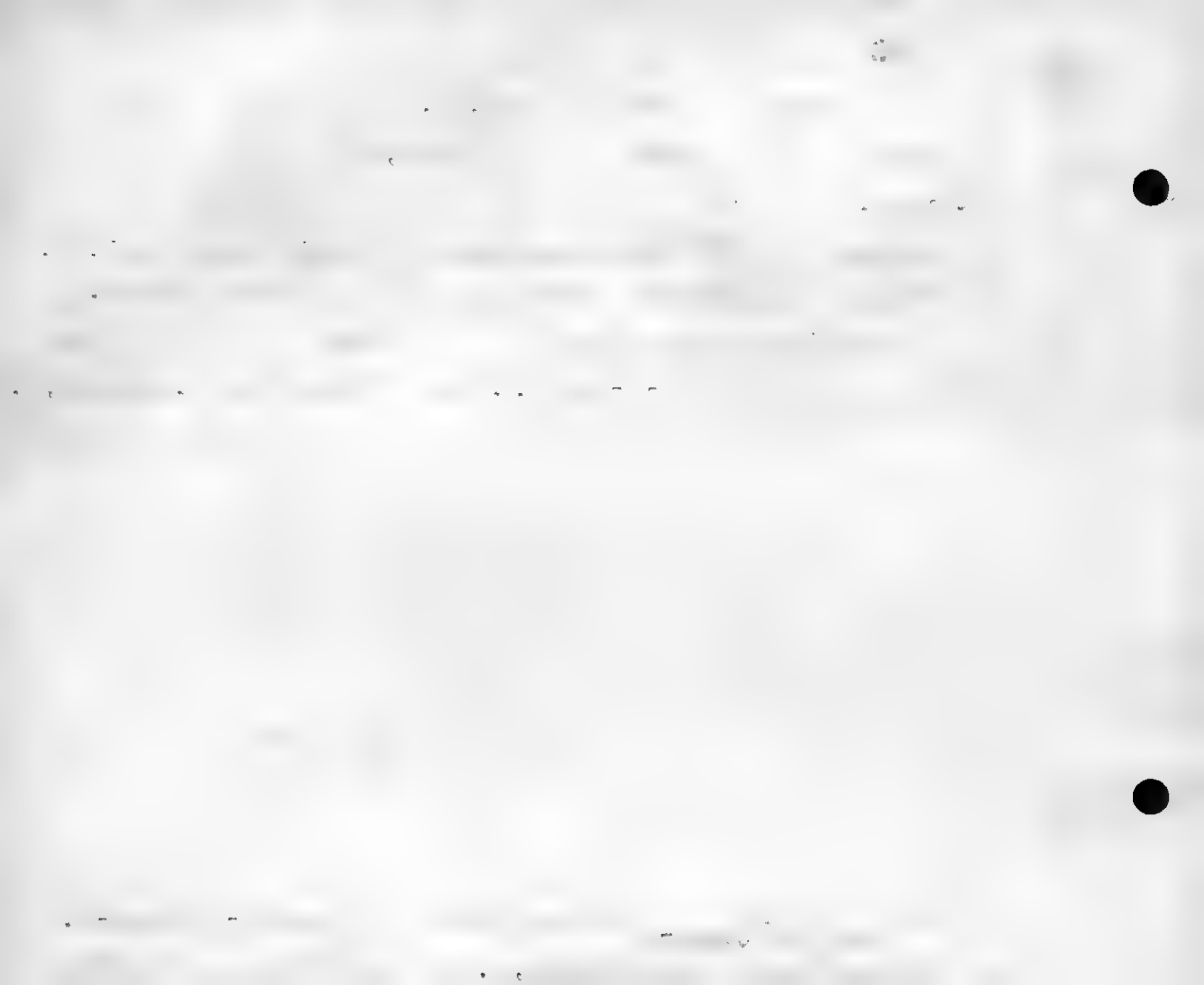
1. DECEASED-NAME (Type or Print)			First <b>LAWRENCE</b>			Middle <b>GROVE</b>			Last <b>COOLEY</b>			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>JUNE</b> Day <b>30</b> Year <b>68</b>			2b. HOUR <b>P.</b>		
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>1/13/1914</b>		6 AGE (In years last birthday) <b>54</b> YRS		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN. <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>July</b> Day <b>3</b> Year <b>19</b>			2d. HOUR <b>8:40</b> M.		
7a. BIRTHPLACE (State or foreign country)				7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9 COUNTY OF DEATH <b>WASHINGTON</b>					
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1325 OUTER DRIVE.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>NIGHT SUPERVISOR AIR FREIGHT CO.</b>				12b. KIND OF BUSINESS OR INDUSTRY <b>CO.</b>					
13a. USUAL RESIDENCE (Where deceased administered) STATE <b>MARYLAND</b>				13b. COUNTY <b>WASHINGTON</b>				13c. ASIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13e. STREET AND NUMBER <b>1325 OUTER DRIVE</b>					
14 FATHER'S NAME First <b>JOSEPH</b> Middle <b>COOLEY</b> Last <b>COOLEY</b>				15 MOTHER'S MAIDEN NAME First <b>FANNIE</b> Middle <b>GROVE</b> Last <b>GROVE</b>													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO (If yes give war or dates of service) <b>21407-4042</b>				17. INFORMANT ADDRESS <b>MRS. JEANNETTE COOLEY P.O. BOX 473 RIDGELEY W. VA.</b>									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gunshot Wound Of Head</b> <b>955X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Instant</b>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>976X</b>																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>P.M. June 30, 68</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Shot in head with rifle, self inflicted.</b>									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>				21f. LOCATION Street or R.F.D. No. City or Town County State <b>Outer Drive, Hagerstown, Washington, Md.</b>									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <b>Dr. E. W. Ditte, Jr.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MED. EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditte, Jr.</b>				ADDRESS (Street, City, Town, or County) <b>215 W. Washington St., Hagerstown, Md.</b>				22b. DATE SIGNED <b>July 3, 1968</b>									
23a. BURIAL, CREMATION, REMAINS (Specify) <b>BURIAL</b>				23b. DATE <b>7/5/68</b>				23c. NAME OF CEMETERY OR CREMATORY <b>CEDAR LAWN MEM. GARDENS HAGERSTOWN WASH. MD.</b>				23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>					
24. FUNERAL DIRECTOR <b>W. J. Norman, Hagerstown, Md.</b>				ADDRESS				25a. REC'D BY REGISTRAR <b>JUL - 8 1968</b>				25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (page 1) and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Clyde Edwin Cross, Sr.						June 30 1968			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
Male		White		March 6, 1909		59 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Md.			
Mt. Lena, Md.		USA				Washington			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital		Machinist Helper		Equip. Mfg.			
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		114 Buena Vista Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME		First	Middle
Cornelius Sylvester Cross						Martha Zahn			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			
No			213-18-9984			C.W. Cross 114 Buena Vista Ave. Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial infarction</u> 4/10/68 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Dis.</u> 1-2 yrs. DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Cardio. Dis.</u> 1-2 yrs.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Hypertension</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No		City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>20 Nov</u> , 19 <u>65</u> , to <u>date</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>30 June</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Richard T. Binford, M.D.</u>						22c. DATE SIGNED <u>1 July 68</u>			
22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.						22e. ADDRESS 1135 Potomac Avenue		Hag. Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		7/3/68		Rest Haven Cemetery		Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR <u>Wm. C. Hoot</u>				ADDRESS Rest Haven Funeral Chapel Hagerstown, Md.		25a. REC'D BY REG. STRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>WASH</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cearfoss</u> Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cearfoss</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Cearfoss, Maryland</u>		d. STREET ADDRESS <u>Hagerstown-Cearfoss, Md.</u>	
3. NAME OF DECEASED (Type or print) <u>George W. Cunningham</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/4/1905</u>
9. AGE (In years last birthday) <u>63</u> yrs.		10. IF UNDER 1 YEAR Months Days	
11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor Cunningham</u>		14. MOTHER'S MAIDEN NAME <u>Lulu Smith</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-09-6141</u>	
17. INFORMANT <u>Lucille Cunningham - Cearfoss, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerotic heart disease +</u> DUE TO (c) <u>Senile arterio sclerosis</u>	
19. INTERVAL BETWEEN ONSET AND DEATH <u>20 Hrs.</u>		20. 10 yr	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
21. 22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			
22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)			
22c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19			
22d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
22e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
22f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>May 9, 1968</u> to <u>June 10, 1968</u> ; that (I) (we) last saw the deceased alive on <u>May 3, 1968</u> , and that death occurred at <u>9:30</u> M. from the causes and on the date stated above.			
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D.			
22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>			
22d. ADDRESS <u>217 W. Washington Street Hagerstown, Maryland</u>			
22e. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
22f. ATTENDING PHYS. <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			
23b. DATE THEREOF <u>6/12/68</u>			
23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>			
23d. LOCATION (City, town or county) (State) <u>Greencastle Pa.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>A. E. Hymnch - Greencastle, Pa.</u>			
25a. REC'D BY REGISTRAR <u>JUN 13 1968</u>			
25b. REGISTRAR'S SIGNATURE <u>John Judge</u>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Katherine Dauchey Cunningham</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>13</b> Year <b>1968</b>			2b. HOUR <b>M</b>								
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>March 15, 1886</b>		6. AGE (in years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN <b></b>				
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			Md.					
10. CITY OR TOWN OF DEATH <b>Boonsboro</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Fairney-Keedy Mem. Home</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Civil service</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Fed. Gov.</b>					
13a. USUA. RESIDENCE (Where deceased lived, admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Hagerstown</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER <b>RFD 3</b>		
14. FATHER'S NAME First <b>Eliphalet R. Merry</b> Middle <b></b> Last <b></b>						15. MOTHER'S MAIDEN NAME First <b>Lizzie</b> Middle <b>Center</b> Last <b></b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b></b>			17. INFORMANT Address <b>Mrs. Earl Grove, Hagerstown, Md.</b>								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b></b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4201</b>														
19a. DATE OF OPERATION <b></b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b></b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b></b>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. <b></b> Month <b></b> Day <b>19</b> Year <b>68</b> P.M. <b></b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, item 1B.) <b></b>								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b></b>			21f. LOCATION Street or R.F.D. No <b></b> City or Town <b></b> County <b></b> State <b></b>								
22a. I certify that (I) (this hospital) attended the deceased from <b>Sept 5, 1967</b> , to <b>June 13, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 13, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>Royal A. Hoffman</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>6/14/68</b>					
22d. PHYSICIAN'S NAME (Type) <b>Royal A. Hoffman</b>						22e. ADDRESS <b>214 N. Potomac St. - Hagerstown Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>			23b. DATE <b>6-15-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lewinsville Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Lewinsville, Virginia</b>						
24. FUNERAL DIRECTOR <b>Minnick Funeral Home, Hagerstown, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>JUN 17 1968</b>			25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>					

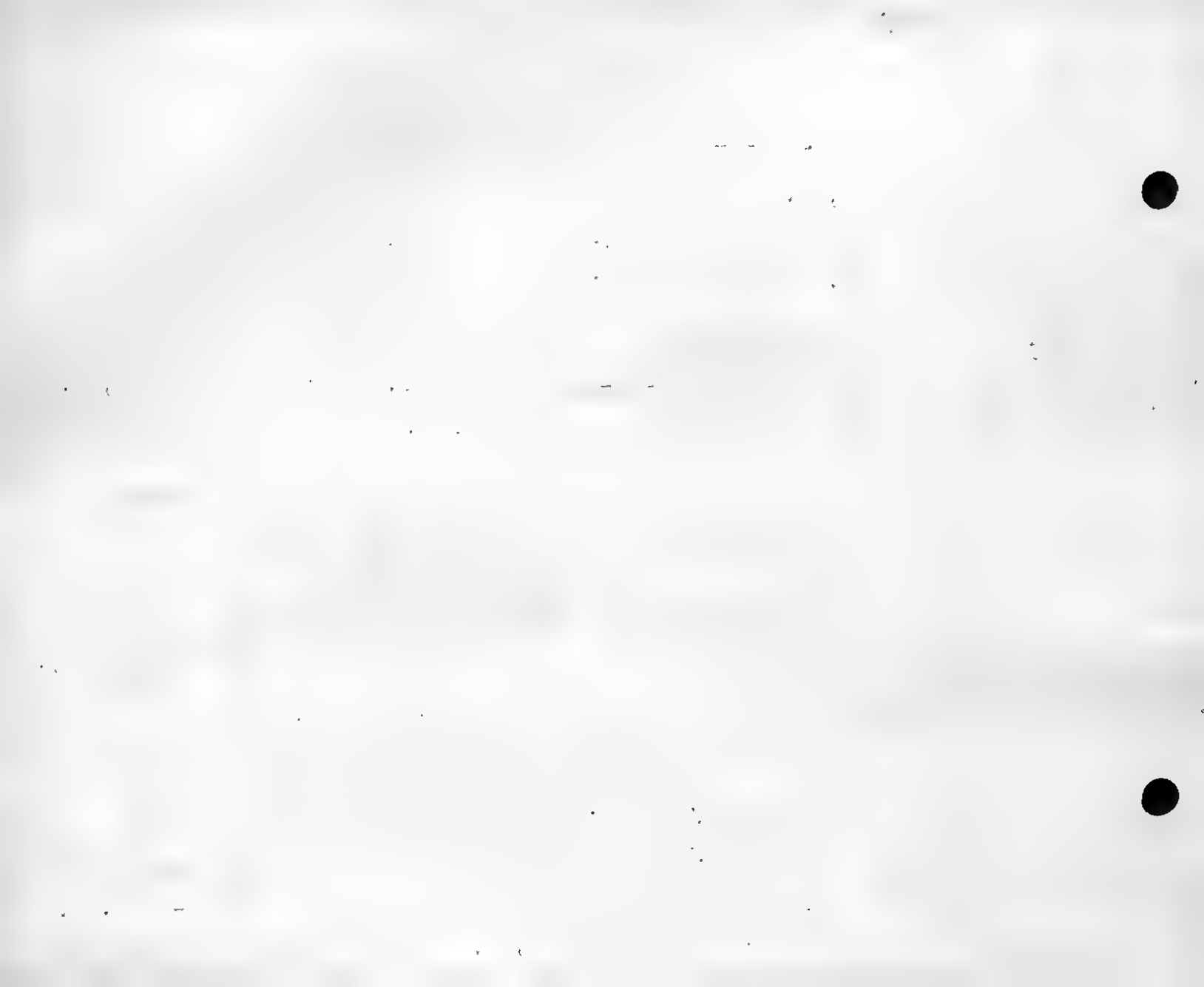


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR	
CAROL L. ouise DE VORE						EST <input checked="" type="checkbox"/> Month 6 Day 3 Year 68		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN		2c DATE PRONOUNCED DEAD Month 6 Day 3 Year 1968	
F	White	3-9-1940	28 YRS					2d HOUR M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Robertsdale, Pa.		U S				Washington			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash. Co. Hosp.			Housewife			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Pa.			Cumberland			Shippensburg		NO <input type="checkbox"/>	
14. FATHER'S NAME			15 MOTHER'S MAIDEN NAME			13e STREET AND NUMBER			
First Middle Last			First Middle Last			17 S Earl St			
James Frank Brown			Annie Hess						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT		ADDRESS	
NO			181-32-3926			Donald C. Devor		Shippensburg, Pa.	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compound fractured skull brain-stem injury</u> Days 816.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20 AUTOPSY?			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH			21b TIME OF INJURY Month, Day, Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
7-50 PM 5/28 68			Passenger in car hitting utility pole.						
21d INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT AT WORK			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No			City or Town County State
			Street W. King St.			Shippensburg			Frank. Pa.
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b DATE SIGNED			
EXAMINER'S NAME (Type)			M.D.			ASSISTANT MEDICAL EXAMINER			
Howard N. Weeks			Wash. Co.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			6/3/68
ADDRESS			ADDRESS (Street, city, town, or county)						
1438 Shippensburg, Pa.			Hagerstown, Md.						
23a BURIAL, CREMATION, REMOVAL (Specify)			23a DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)
burial			6-6-1968			Spring Hill Cemetery			Shippensburg-Gulb. Pa.
24 FUNERAL DIRECTOR			ADDRESS			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE
G. Van Noy			1438 Shippensburg, Pa.			DATE JUN 7 1968			Charles J. J. J.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Imogene Mom Dudley						June 24, 1968			3:15 P.M.
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR	
female		white		7-9-1880		87 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
New Jersey		USA				Washington Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Wash. County Hospital		Vice President		Printing, Co.			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Wash.		Hagerstown				806 Frederick, St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Edward W. Insley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
no				219-20-2176		Mr. James I. Dudley Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic pulmonary carcinoma								13 yr.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 114X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of the breast								27 years	
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Arteriosclerotic heart disease and chronic valvular disease									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from June 24, 1968, to June 24, 1968, that (I) (we) lost saw the deceased alive on June 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE B. B. Kneisley M.D.		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/25/68			
22d. PHYSICIAN'S NAME (Type)		B. B. Kneisley, M.D.		22e. ADDRESS		148 West Washington Street Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-26-1968		Rest Haven Cemetery		Hagerstown, Md.			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md,				JUN 27 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First MIDDLE Last NORA PEARL EARLEY			2a. DATE OF DEATH JUNE Month 23 Day 1968		2b. HOUR 10:48 AM	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5/22/1881		6. AGE (In years last birthday) 87 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON		Md.	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 509 FREDERICK ST.		12a. USUAL OCCUPATION (Kind of work done during life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Res. before adm. ssion) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 509 FREDERICK ST.	
14. FATHER'S NAME First MIDDLE Last FRANKLIN WOLF			15. MOTHER'S MAIDEN NAME First MIDDLE Last LAURETTA MARTZ						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <input type="checkbox"/> NO (unknown) <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO 217-32-5686B		17. INFORMANT MR. NORMAN S. EARLEY SR.		Address HAGERSTOWN MD.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gangrene of rt. foot 44 DUE TO, OR AS A CONSEQUENCE OF Peripheral atherosclerotic arterial disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c) yrs.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 6/17/68, 19 to 6/23/68, that (I) (we) last saw the deceased alive on June 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE H. N. Weeks				DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/24/68	
22d. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.				22e. ADDRESS 580 Northern Avenue, Hagerstown, Md.					
23a. BURIAL CREMAT. REMOVAL BURIAL		23b. DATE 6/26/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.			
24. FUNERAL DIRECTOR W. J. Norment				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL - 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

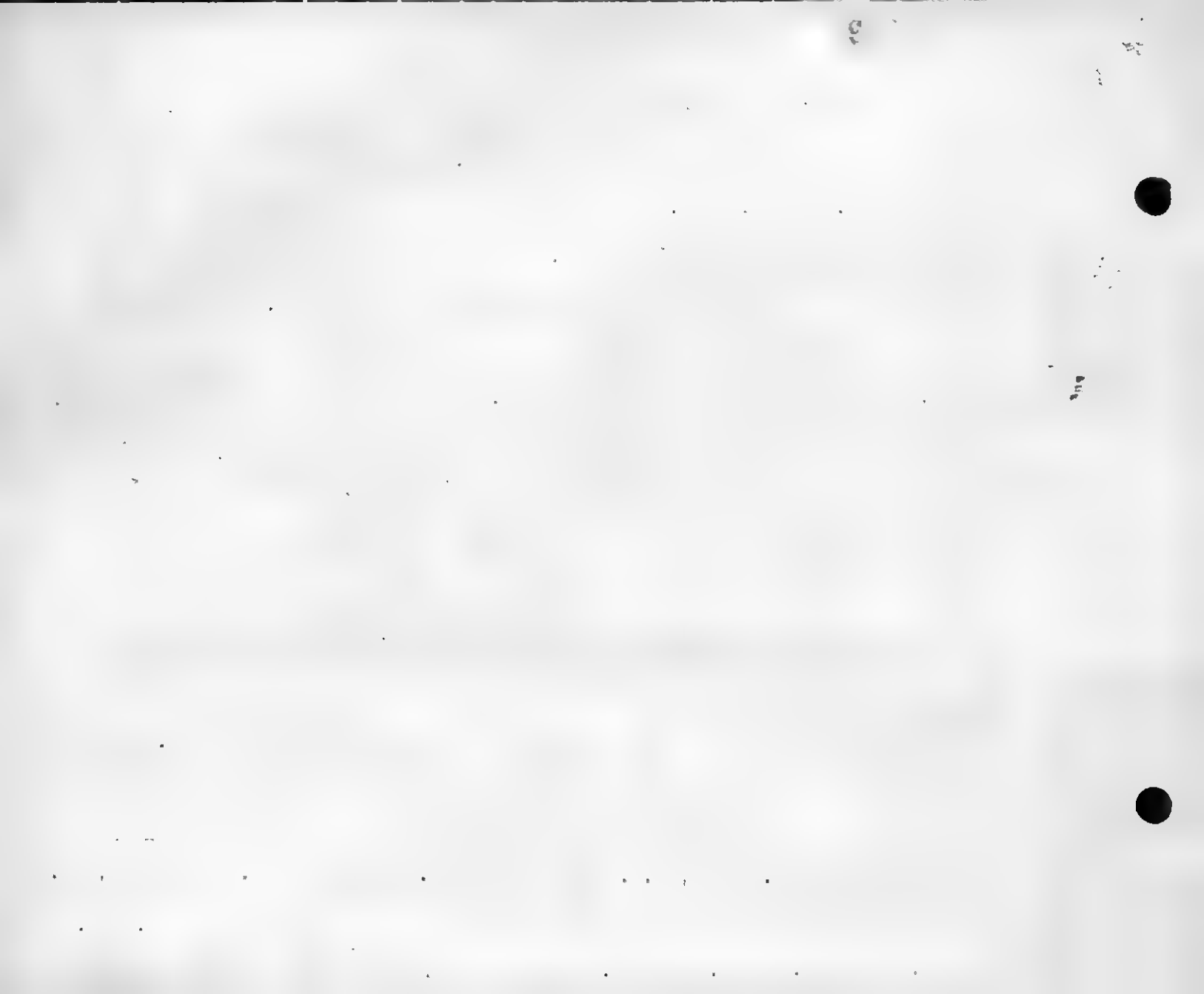
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

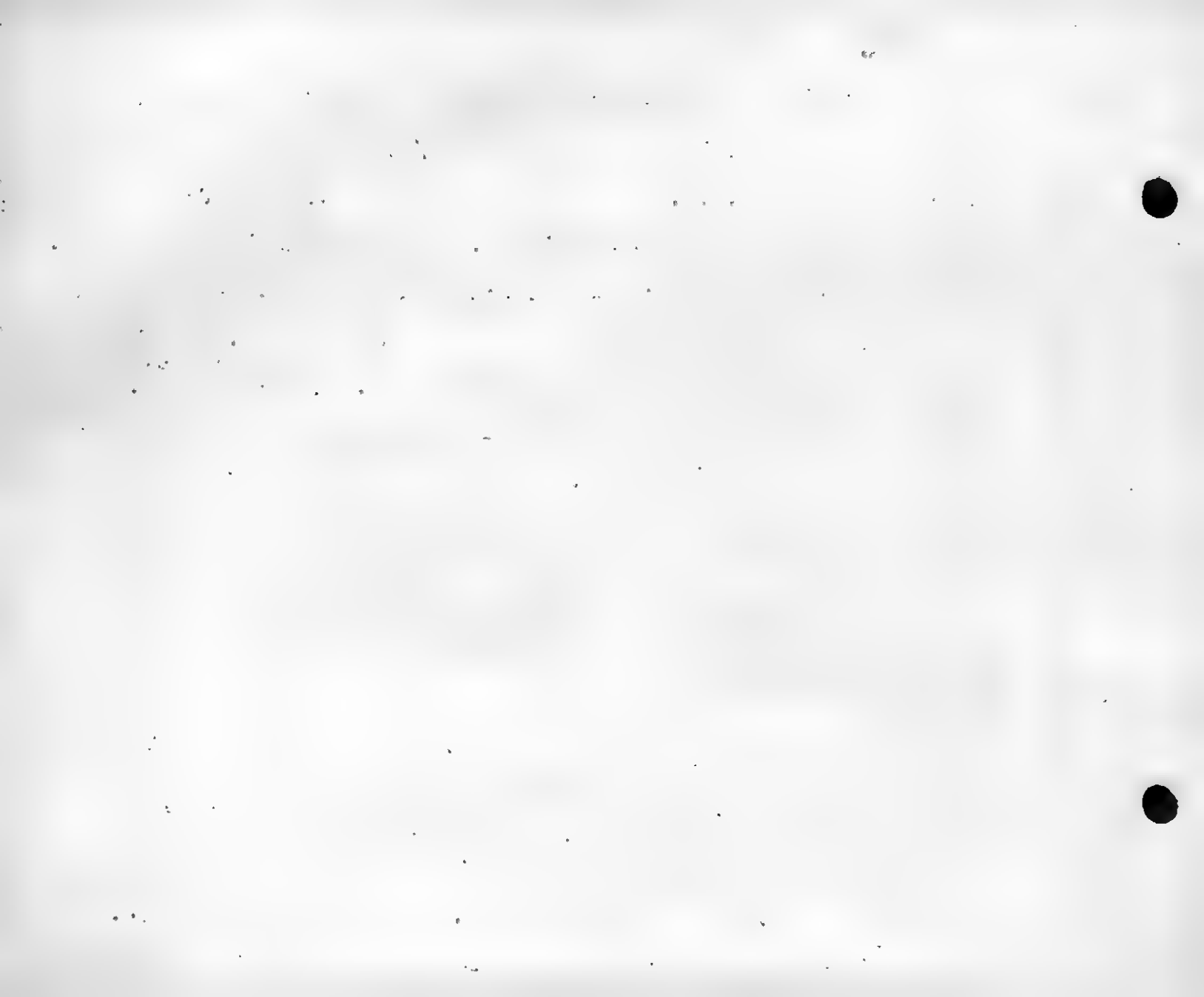
1. DECEASED-NAME (Type or print) First Middle Last <b>Virgie May Fahrney</b>			2a. DATE OF DEATH Month Day Year <b>June 24, 1968</b>			2b. HOUR <b>6:00 PM</b>			
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 15, 1884</b>		6. AGE (In years last birthday) <b>84</b> YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN <b>4 9</b>	
7a. BIRTHPLACE (State or foreign country) <b>San Mar, Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Homemaker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Boonsboro</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>Rfd. 2</b>	
14. FATHER'S NAME First Middle Last <b>Joseph Fahrney</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Jennie Cost</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) <b>No.</b>		16b. SOCIAL SECURITY NO. <b>216-46-4667</b>		17. INFORMANT Address <b>Mrs. Mary Fahrney, Rfd. 2, Boonsboro, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>arteriosclerotic heart disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Jan 19 62</b> to <b>June 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 23, 19 68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Edson B. Moody</b>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-27-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Edson B. Moody, M.D.</b>				22e. ADDRESS <b>363 S. Cleveland Ave. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6-27-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>San Mar, Wash. Co., Md.</b>			
24. FUNERAL DIRECTOR ADDRESS <b>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</b>				25a. REC'D BY REGISTRAR <b>JUL - 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or print)			First Middle Last LAURA CATHERINE FAUVER			2a DATE OF DEATH JUNE Month 29 Day 1968		2b HOUR 8A M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 8/1/1903		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) MARYLAND		7b CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WASHINGTON MD			
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 41 E. ANTIETAM ST.		12a. USUAL OCCUPATION (Kind of work done during last year) REGISTERED NURSE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b COUNTY WASHINGTON		13c CITY OR TOWN HAGERSTOWN		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER 41 E. ANTIETAM ST.	
14. FATHER'S NAME First Middle Last JOHN H. FAUVER			15. MOTHER'S MAIDEN NAME First Middle Last LAURA C. BRAKE			16. SOCIAL SECURITY NO. 213-24-7598			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 213-24-7598			17. INFORMANT MISS ETHEL G. FAUVER HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF. (b) <u>Atherosclerosis, General</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Not known</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 2/6/68, 1968, to 6/29, 1968, that (I) (we) last saw the deceased alive on 5/20/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>A. H. Rieger</u>				DEGREE ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/1/68	
22d. PHYSICIAN'S NAME (Type) A. H. Rieger				22e. ADDRESS 119 E. Antietam St. Hagerstown					
23a. BURIAL, CREMATION, ETC. BURIAL		23b. DATE 7/2/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.			
24 FUNERAL DIRECTOR W. J. Norment				ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL - 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH																	
1. DECEASED NAME (Type or print) Eva			First Eva		Middle Ford		Last Ford		2a. DATE OF DEATH June 30 1968		2b. HOUR 8:00AM						
3. SEX Female			4. RACE White			5. DATE OF BIRTH Oct. 12, 1877			6. AGE (In years last birthday) 90 YRS.			IF UNDER 1 YEAR MONTHS 8 DAYS 18		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) Boonsboro, Md.			7b. CITIZEN OF WHAT COUNTRY? U. S. A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Jackson Convalescent Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housekeeper			12b. KIND OF BUSINESS OR INDUSTRY Own Home								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Boonsboro			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 24 Potomac St.						
14. FATHER'S NAME Joshua			First Joshua		Middle Ford		Last Ford		15. MOTHER'S MAIDEN NAME Mary Brish			First Mary		Middle Brish		Last Brish	
16a. WAS DECEASED EVER IN U. S. ARMED FORCES? Yes, no, or unknown No.			16b. SOCIAL SECURITY NO. 220-30-7612			17. INFORMANT Miss Elizabeth Wheeler, 24 Potomac St.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> 4409 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years.																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) +56																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No		City or Town		County		State					
22a. I certify that (I) (this hospital) attended the deceased from <u>1-10-</u> , 19 <u>65</u> , to <u>6-30-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE John H. Bast			DEGREE M.D.			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 7-1-68								
22d. PHYSICIAN'S NAME (Type) Joseph Secondari, M.D.			22e. ADDRESS 21 N. Main St., Boonsboro, Md.														
23a. BURIAL, CREMATION, OR OTHER DISPOSAL Burial			23b. DATE 7-2-68			23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery			23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md.								
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.						25a. REC'D BY REGISTRAR JUL - 5 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

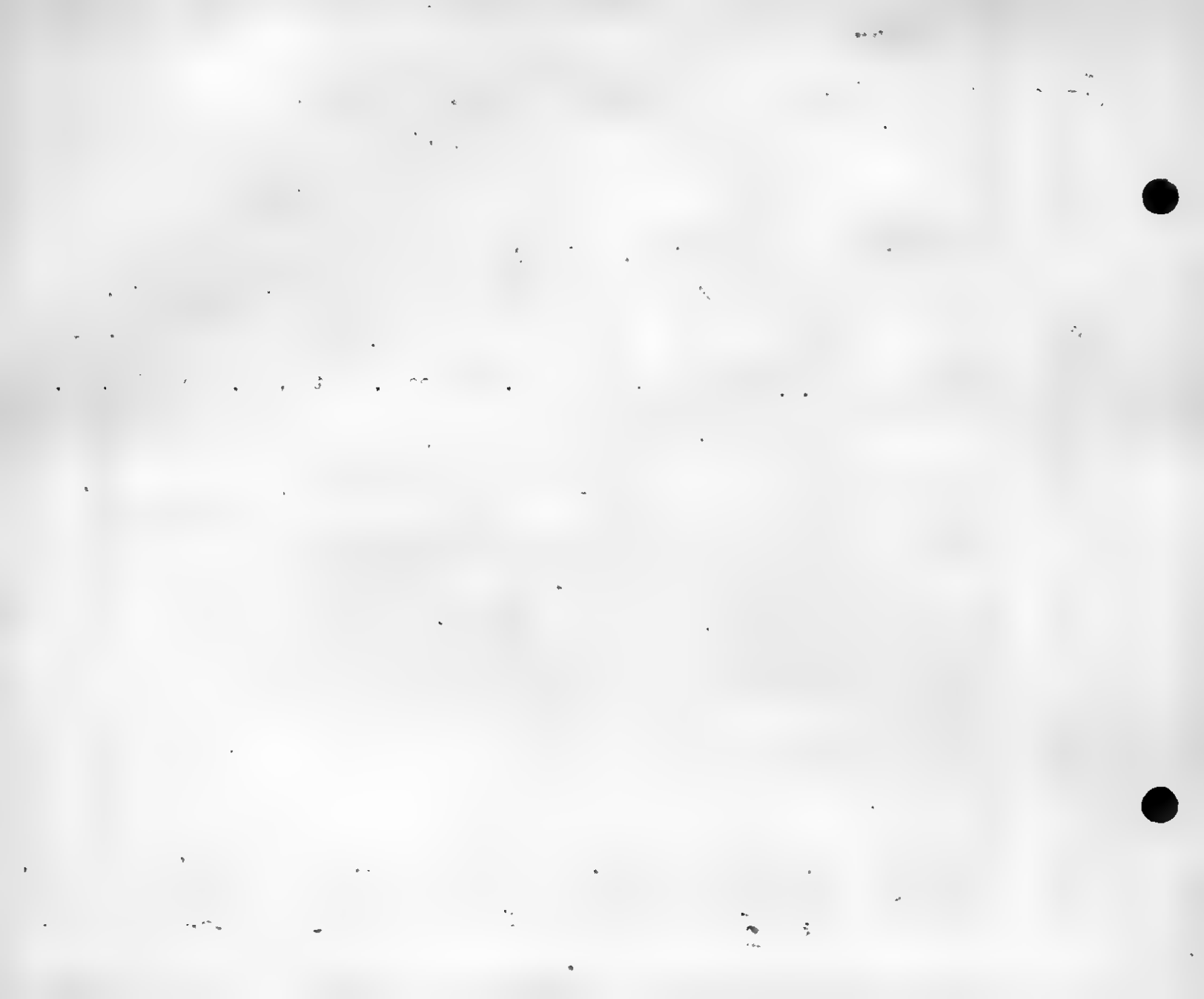


## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Charles Wesley Foster					June Month 9 Day 1968 Year		10 55 PM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Male	White		1/17/96		72 YRS.		IF UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH		
Ohio		USA				WASHINGTON Md.		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY
HAGERSTOWN			WESTERN MD. STATE HOSPITAL			restaurant employee		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Frederick		Frederick	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1000L West 7th St.
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME					
First Middle Last Francis Foster			First Middle Last Charlotte Kaderly					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address			
Yes			W.W. One 221-07-6626		Mr. Charles W. Foster, Jr. Frederick, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiorespiratory failure</u>								3 days
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pulmonary Emphysema</u>								25 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)								
<u>Cardiac Hypertrophy</u>								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
2/17/68		Interoctantive fracture of right femur		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
		HOUR A.M. Month Day Year P.M. 19						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>March 25, 1968</u> , to <u>June 9, 1968</u> , that (I) (we) lost the deceased alive on <u>June 9, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Dr. U. Porciuncula M.D.</u>				22c. DATE SIGNED <u>June 10, 1968</u>				
22d. PHYSICIAN'S NAME (Type) <u>Dr. U. Porciuncula, M.D.</u>				22e. ADDRESS <u>Western Md. State Hosp., Hagerstown, Md.</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
		6-12-68		Silverbrook		Hagerstown Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
R. E. Daily & Son				Frederick, Md.		DATE JUN 14 1968 <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print) <i>CATHERINE</i> First Middle Last <i>CANDLER FOX</i>						2a. DATE KNOWN OF ESTI-DEATH MATED <input checked="" type="checkbox"/> 6/13 1968 1 AM M			2b. HOUR		
3 SEX <i>FEMALE</i>		4 RACE <i>WHITE</i>		5 DATE OF BIRTH <i>SEPT 26 1902</i>		6 AGE (in years most birthday) <i>65</i> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>				7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <i>WASHINGTON</i> Md	
10 CITY OR TOWN OF DEATH <i>HAGERSTOWN</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WASHINGTON COUNTY HOSPITAL</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>HOMEMAKER</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital - Residence before admission) STATE <i>MARYLAND</i>				13b. COUNTY <i>WASHINGTON</i>		13c. CITY OR TOWN <i>LANTZ</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14 FATHER'S NAME First Middle Last <i>CHARLES B CANDLER</i>						15 MOTHER'S MAIDEN NAME First Middle Last <i>HARRIETTE BUCK</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i>				16b. SOCIAL SECURITY NO.		17 INFORMANT <i>1124 COSBY STREET MRS T P WOODING LYNCHBURG VIRGINIA</i>					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>4129 congestive failure</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <i>or Pericard. Conduction Dis</i> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>hrs</i> <i>yes</i>											
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Howard Weeks</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <i>6/13/68</i>			
EXAMINER'S NAME (Type) <i>H. N. WEEKS</i>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				550 Northampton Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i>				23b. DATE <i>6/13/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL CEMETERY</i>		23d. LOCATION (City or Town) <i>LYNCHBURG</i> (County) <i>CAMPBELL</i> (State) <i>VA.</i>			
24 FUNERAL DIRECTOR <i>Charles S. Rouse</i> ADDRESS <i>HAGERSTOWN MARYLAND</i>						25a. REC'D BY REG. STRAIP <i>JUN 18 1968</i>		25b. REGISTRAR'S SIGNATURE <i>James J. ...</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR 11:45 PM	
CHARLES WALTER GANO						June 30, 1968			
3. SEX Male		4. RACE White		5. DATE OF BIRTH Nov. 8, 1910		6. AGE (In years last birthday) 57 YRS.		IF UNDER 1 YEAR MONTHS DAYS 7 22	
7a. BIRTHPLACE (State or foreign country) West Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md			
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Williamsport RFD #2			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Laborer			12b. KIND OF BUSINESS OR INDUSTRY Lannery	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland			13b. CITY OR TOWN Washington		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RFD #2		
14. FATHER'S NAME Charles M. Gano			15. MOTHER'S MAIDEN NAME Ella Barrett						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b. SOCIAL SECURITY NO. 219-12-1044		17. INFORMANT Williamsport, Maryland Mrs. Mabel H. Gano RFD #2				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolus</u> 472X DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cor Pulmonale</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pulmonary Emphysema and Fibrosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes ?? ??	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 5271 None									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from <u>05/29/68</u> 19__, to <u>06/30/68</u> 19__, that (I) (we) lost the deceased alive on <u>06/18/68</u> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <i>Archie Robert Cohen M.D.</i>					22c. DATE SIGNED 07/04/68		22d. PHYSICIAN'S NAME (Type) Archie Robert Cohen, M.D.,		
22e. ADDRESS Clear Spring, Maryland 21722									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE July 3, 1968		23c. NAME OF CEMETERY OR CREMATORY Cedar Lawn Memorial Park		23d. LOCATION (City or Town) (County) (State) Hagerstown, Washington, Maryland			
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Maryland					25a. REC'D BY REGISTRAR JUL - 5 1968		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

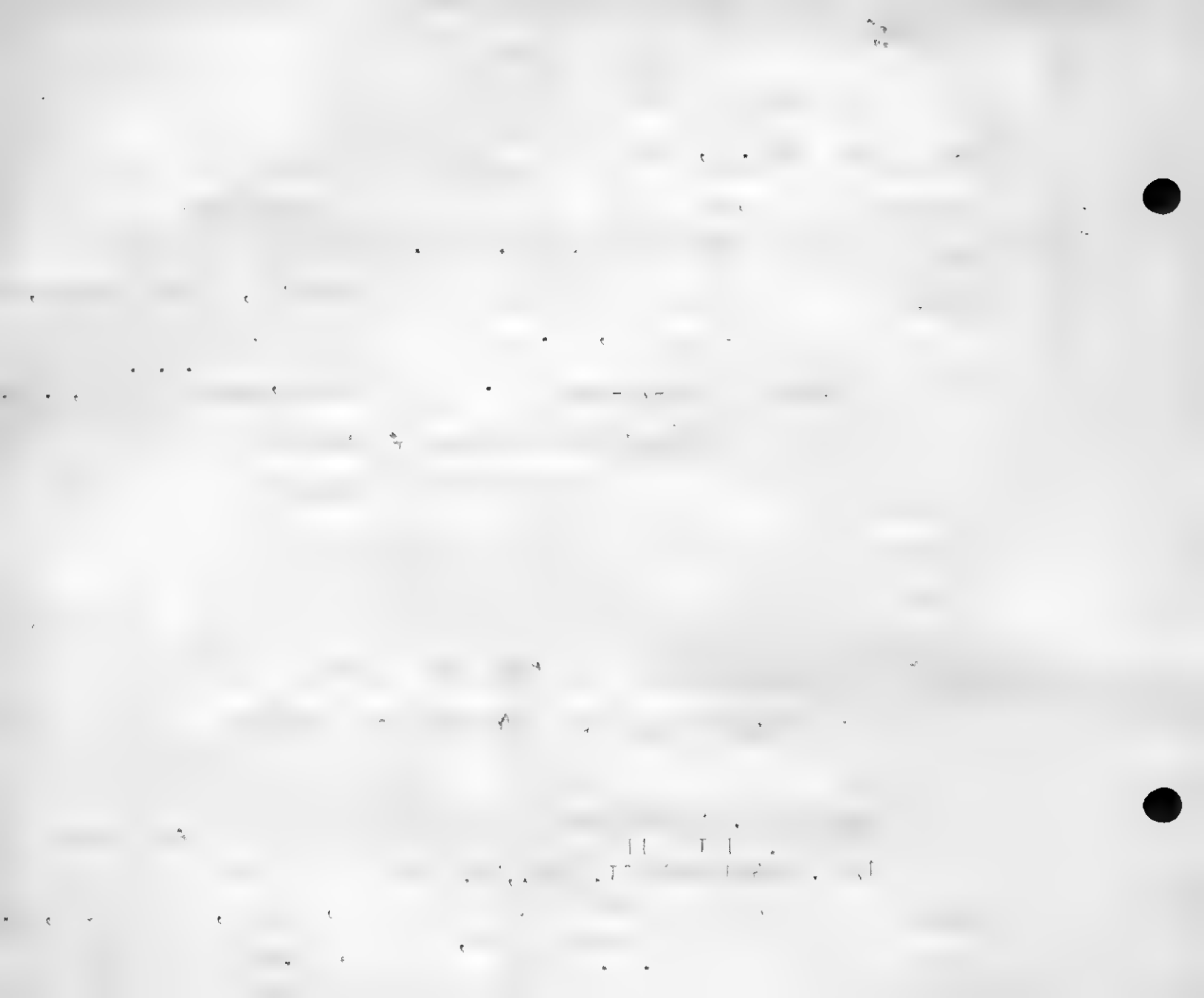


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
ROGER LEE GIFFIN						Month Day Year			40 12 PM
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)	7E UNDER 1 YEAR	7F UNDER 24 HRS	2c. DATE PRONOUNCED DEAD		2d. HOUR
Male	White	Apr. 28, 1946		22 YRS	MONTHS	DAYS	HOURLS	MIN	40 2 PM
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.
Maryland		USA					Washington		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Dargan (Rural)			DOA Washington Co. Hosp.			Carpenter		Constructio	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admiss an) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Washington		Antietam		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		RFD# 1, Harpers Ferry, WV
14. FATHER'S NAME First Middle Last					15. MOTHER'S MAIDEN NAME First Middle Last				
Ellsworth Robert Giffin, SR.					Leda Constance Saylor				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT ADDRESS R.F.D.# 1				
No			None		Mrs. Jo Ann Giffin, Harpers Ferry, W. Va.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Skull Fracture &amp; Massive</u>									
8119 DUE TO, OR AS A CONSEQUENCE OF <u>Brain Stem Injury</u>									20 Min
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION									19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?
19c. DATE OF OPERATION									19d. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
			12 PM 6-15 1968			Auto Accident			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> HOT WHILE <input checked="" type="checkbox"/> AT WORK			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc)			21f. LOCATION Street or R.F.D. No City or Town County State			
			Harpers Ferry, Md			Near Dargan wash Md			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED			
EDWARD W. DITTO III			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			6-15-68			
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			
217 W. WASHINGTON ST, HAG, MD.									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			6/17/68		Boonsboro Cemetery		Boonsboro, Washington, Md.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
J. Donald Ecker			Harpers Ferry, W. Va. 25425			DATE JUN 17 1968		J. Charles Jones	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)  
30M. REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR
Louie Ernest Giff						June 3, 1968			10:50 PM
3 SEX		4. RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		F UNDER 1 YEAR MONTHS DAYS	
Male		White		Dec. 23, 1905		62 YRS.		5 10	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH			
Antietam, Md.		U. S. A.				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington Co. Hospital		U. S. Marine Corps-		Machinist			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown				317 S. Potomac St.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Mayberry					Giff	Martha			Holmes
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT				
Yes			W. W. Two		Mr. Walter S. Giff, Rfd. 1, Keedysville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acc. Cardiac Failure &amp; pulmonary</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4124 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Edema - Due - Arteriosclerotic heart</u>									4 days
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last (c) <u>chronic &amp; pulmonary emphysema</u>									20-25 yr
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Benign Prostate Hypertrophy</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION		Street or R.F.D. No.		City or Town	County State
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1968</u> , to <u>June 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Edward W. Ditto III</u>					DEGREE ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-5-68
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Edward W. Ditto, III, M.D.					217 W. Wash. St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)	(State)
Burial		6-7-68		Samples Manor Cemetery		Samples Manor, Wash. Co., Md.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.							JUN 10 1968		<u>John H. Bast, Jr.</u>





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR	
John			William	Gladwell	June 27 1968			M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS		
Male		White		January 17, 1917		51 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Harrisonburg, Va.		USA				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County Hospital			Locomotive Engineer		Railroad		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland		Washington		Hagerstown				525 Guilford Ave.		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last	
Kemp			M	Gladwell	Edna	Virginia			Pittington	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT				Address	
Yes			1934-39 1940-43		Mrs. J.W. Gladwell				525 Guilford Ave. Hagerstown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Terminal Pneumonia</u>								5 Days		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Subarachnoid Hemorrhage</u>								10 Days		
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cerebral Artery</u>								?		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
None										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes				
6/17/68		Subarachnoid Hemorrhage								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I (this hospital) attended the deceased from June 12 1968 to June 27 1968, that I (we) last saw the deceased alive on June 27 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, I (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>J.H. Poye</u>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/27/68				
22d. PHYSICIAN'S NAME (Type) <u>J.H. Poye M.D.</u>				22e. ADDRESS <u>Hagerstown, Md.</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6/30/68		Rest Haven Cemetery		Hagerstown-Washington-Md.				
24. FUNERAL DIRECTOR <u>Wm. G. Mont</u>				ADDRESS <u>Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Rest Haven Funeral Chapel						DATE JUL - 1 1968		<u>J. Charles Judge</u>		

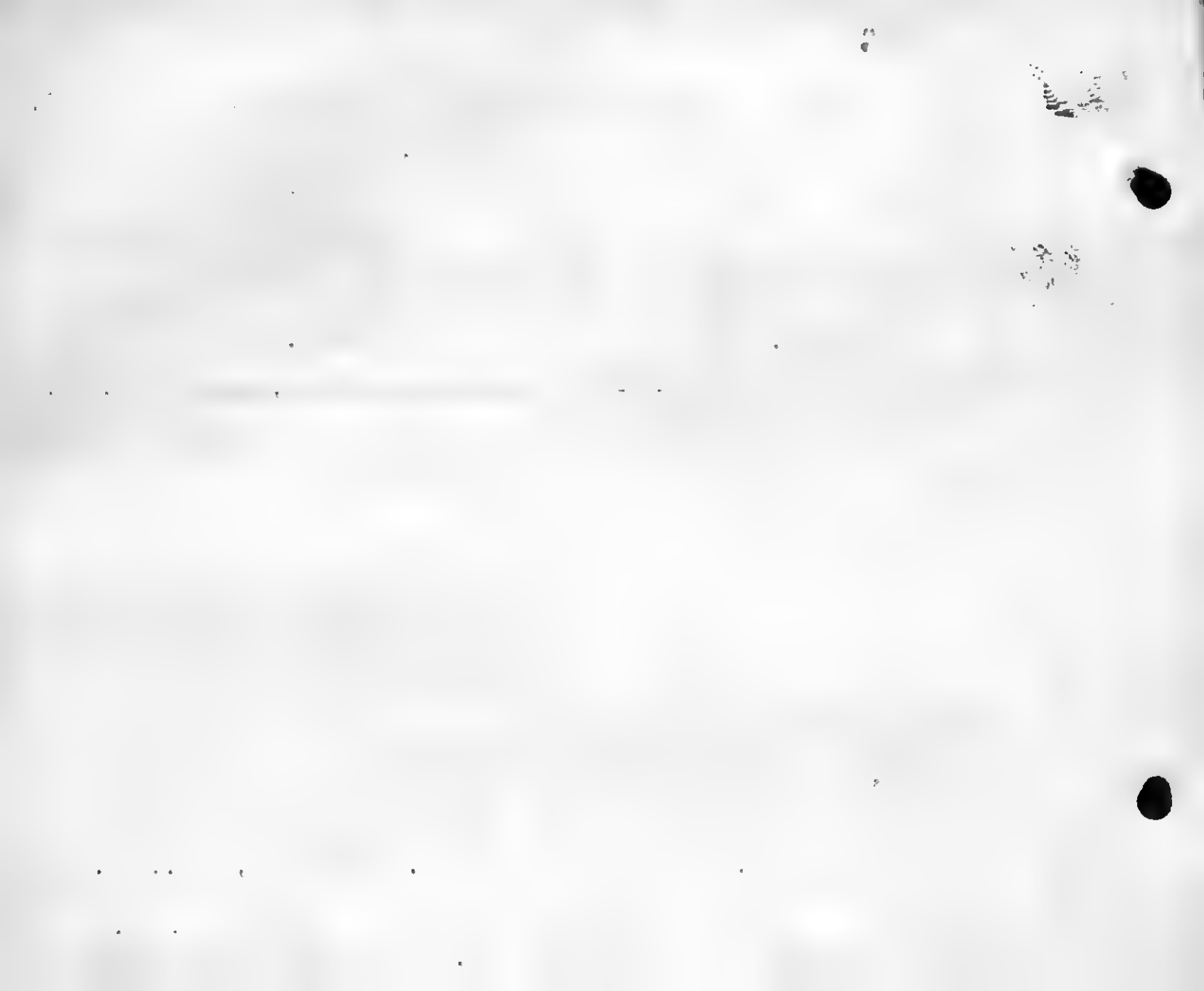
71844-215

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>William Windy Godlove</b>			2a. DATE OF DEATH <b>June 27, 1968</b>		2b. HOUR <b>7:30 A.M.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>July 22, 1899</b>		6. AGE (in years last birthday) <b>68</b> YRS.
7a. BIRTHPLACE (State or foreign country) <b>Nebraska</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>RFD 5</b>		12a. USUAL OCCUPATION (Kind of work done during most of work life, even if retired.) <b>carpenter</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>railroad</b>
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. CITY OR TOWN <b>Washington Hagerstown</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET AND NUMBER <b>RFD 5</b>
14. FATHER'S NAME First Middle Last <b>James C. Godlove</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mary A. Roach</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. <b>705-12-2065</b>		17. INFORMANT Address <b>Katherine Godlove, Hagerstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malignancy of Larynx &amp; Metastasis</b> <b>1619</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE <i>Arturo M. Reigo</i>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/27/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>Arturo M. Reigo</b>		22e. ADDRESS <b>159 W. Washington, Hag., Md.</b>				
23a. BURIAL, CREMATION, REINTERMENT (Specify) <b>Burial</b>		23b. DATE <b>6-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Md.</b>		24. FUNERAL DIRECTOR ADDRESS <b>Minnich Funeral Home, Hagerstown, Md.</b>				
25a. REC'D BY REGISTRAR <b>JUL - 1 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

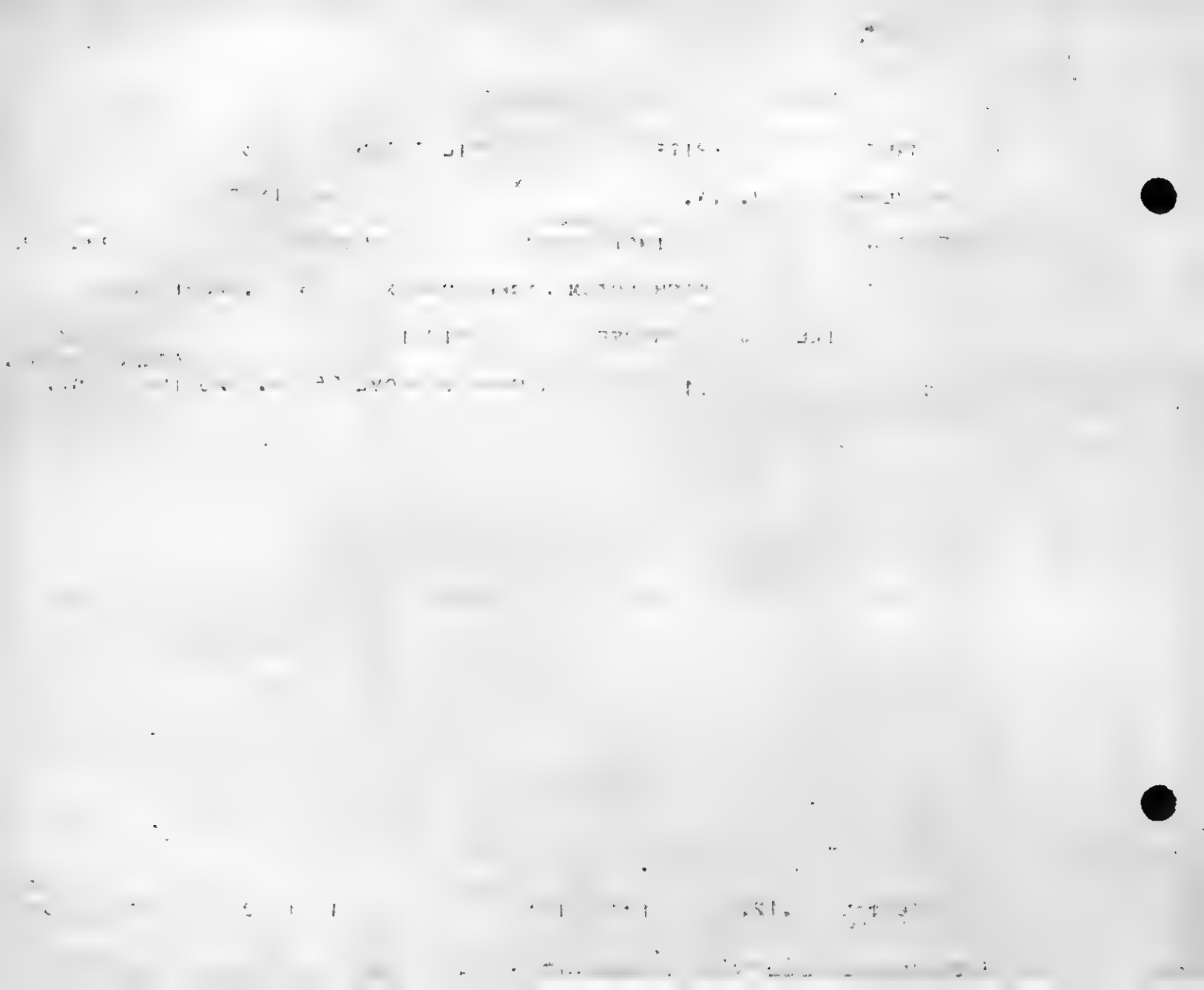
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

1988

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M		
EDGAR		LEE	GROVE		8 9 68				
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE	WHITE		APRIL 1 1885		83 YRS				
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
MARYLAND	U.S.A.				WASHINGTON				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
HAGERSTOWN		WASHINGTON COUNTY		SALESMAN		PRETZEL			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> X <input type="checkbox"/>		13e. STREET AND NUMBER	
MD		WASHINGTON		HAGERSTOWN				755 W. WASHINGTON	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT	
First Middle Last		First Middle Last		NO		218 30 9629A		Address: HAGERSTOWN, MD. MARY S GROVE 755 W. WASHINGTON ST.	
DANIEL J GROCE		CHRISTINE STECK							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Arterio sclerotic heart disease</u>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
(b) _____ DUE TO, OR AS A CONSEQUENCE OF									
(c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
7101									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1968</u> , to <u>June 8, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 8, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
<u>Elden D. Hoachland</u>						6/10/68			
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS							
<u>Elden D. Hoachland</u>		<u>Hagerstown Md.</u>							
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		6.12.68		RIVER VIEW		WILLIAMSPORT WASHINGTON		MD	
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
<u>Howard F. Howell</u>				<u>Hagerstown Md.</u>		DATE JUN 13 1968		<u>J. Charles Jager</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) First Middle Last <b>ALVEY ELWOOD HANN</b>						2a. DATE OF DEATH Month Day Year <b>JUNE 24 1968</b>			2b. HOUR P M <b>1:45 P</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOVEMBER 1, 1918</b>			6. AGE (In years lost to day) YRS. <b>50</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.						
10. CITY OR TOWN OF DEATH <b>HANCOCK</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PENNSYLVANIA AVE.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>LABORER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>ORCHARD</b>			
13a. U.S.A. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HANCOCK</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>PENNA AVE. EXT.</b>			
14. FATHER'S NAME First Middle Last <b>NOT KNOWN</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>VIRGIL VANETTA CLARK</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>YES</b>			16b. SOCIAL SECURITY NO <b>W.W. 2 220.09.7386</b>		17. INFORMANT <b>283 W. MAIN STREET HANCOCK, MD.</b> <b>JAMES ELWOOD HANN</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4109</b> <b>Coronary disease</b> <b>minute</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>,</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION <b>—</b>			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>—</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <b>—</b>			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>—</b>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <b>—</b>			21f. LOCATION Street or R.F.D. No. City or Town County State <b>—</b>			21g. LOCATION Street or R.F.D. No. City or Town County State <b>—</b>			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 24, 1968</b> to <b>June 24, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 24, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>L.M. Schaffer</b>						DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>6/26/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>L.M. SCHAFFER</b>						22e. ADDRESS <b>HANCOCK MD.</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>6/26/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ST. THOMAS EPISCOPAL</b>			23d. LOCATION (City or Town) (County) (State) <b>HANCOCK, WASHINGTON, MD.</b>				
24. FUNERAL DIRECTOR <b>Richard J. Shore</b>						ADDRESS <b>HANCOCK, MD.</b>			25a. REC'D BY REGISTRAR DATE <b>JUN 28 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

1. The first part of the document is a letter from the President of the United States to the Congress, dated January 1, 1861. It is a very important document, as it sets out the policy of the new administration. The President states that he is committed to the principles of liberty and justice for all, and that he will work to maintain the Union. He also mentions the issue of slavery, which was a major point of contention at the time.

2. The second part of the document is a report from the Secretary of the Treasury, dated January 1, 1861. It provides a detailed account of the financial state of the country. The report mentions the national debt, which had increased significantly since the end of the Civil War. It also discusses the various taxes and duties that were levied on the population, and the revenue that was generated from these sources.

3. The third part of the document is a report from the Secretary of the Interior, dated January 1, 1861. It provides a detailed account of the land and natural resources of the country. The report mentions the various territories that were under federal control, and the progress that had been made in developing these areas. It also discusses the various minerals and other resources that were found in these areas, and the potential for future development.

4. The fourth part of the document is a report from the Secretary of the Navy, dated January 1, 1861. It provides a detailed account of the naval forces of the country. The report mentions the various ships and vessels that were in the fleet, and the progress that had been made in building and maintaining these ships. It also discusses the various operations and activities of the navy, and the role that it played in the defense of the country.

5. The fifth part of the document is a report from the Secretary of the War, dated January 1, 1861. It provides a detailed account of the military forces of the country. The report mentions the various regiments and brigades that were in the army, and the progress that had been made in training and equipping these units. It also discusses the various operations and activities of the army, and the role that it played in the defense of the country.

6. The sixth part of the document is a report from the Secretary of the State, dated January 1, 1861. It provides a detailed account of the foreign relations of the country. The report mentions the various countries and nations with which the United States had diplomatic relations, and the progress that had been made in maintaining these relations. It also discusses the various treaties and agreements that had been signed, and the role that the State Department played in the conduct of foreign policy.

7. The seventh part of the document is a report from the Secretary of the Education, dated January 1, 1861. It provides a detailed account of the educational system of the country. The report mentions the various schools and colleges that were in operation, and the progress that had been made in improving the quality of education. It also discusses the various laws and regulations that governed the education system, and the role that the Secretary of Education played in the administration of this system.

8. The eighth part of the document is a report from the Secretary of the Agriculture, dated January 1, 1861. It provides a detailed account of the agricultural industry of the country. The report mentions the various crops and livestock that were raised, and the progress that had been made in improving the efficiency of agricultural production. It also discusses the various laws and regulations that governed the agricultural industry, and the role that the Secretary of Agriculture played in the administration of this industry.

9. The ninth part of the document is a report from the Secretary of the Commerce, dated January 1, 1861. It provides a detailed account of the commercial industry of the country. The report mentions the various businesses and industries that were in operation, and the progress that had been made in promoting the growth of commerce. It also discusses the various laws and regulations that governed the commercial industry, and the role that the Secretary of Commerce played in the administration of this industry.

10. The tenth part of the document is a report from the Secretary of the Marine, dated January 1, 1861. It provides a detailed account of the marine industry of the country. The report mentions the various ships and vessels that were in the fleet, and the progress that had been made in building and maintaining these ships. It also discusses the various operations and activities of the marine industry, and the role that it played in the defense of the country.



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MD  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR	
Arthur Cleo Harbaugh						June 13, 1968			10:55 A.M.	
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. UNDER 1 YEAR MONTHS		8. UNDER 24 HRS. HOURS
male	white		12-26-1900			67 YRS.				
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				Washington				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash. County Hospital			Pharmacist			Drug Store	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Wash.		Hagerstown		YES		872 Mulberry, Ave.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Harry R. Harbaugh			Emma Brown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
no			214-09-2347		Mrs. Edna Harbaugh Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction										3 hrs.
DUE TO, OR AS A CONSEQUENCE OF:										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Arteriosclerotic Heart Disease										3 mo.
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
4 hrs.										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from Sept. 1963, to June 14, 1968, that (I) (we) last saw the deceased alive on June 14, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lloyd A. Hoffman DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					22c. DATE SIGNED 6/15/68					
22d. PHYSICIAN'S NAME (Type) Lloyd A. Hoffman					22e. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		6-15-68		Rose Hill Cemetery			Hagerstown, MD.			
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.					DATE JUN 17 1968		Charles Judger			

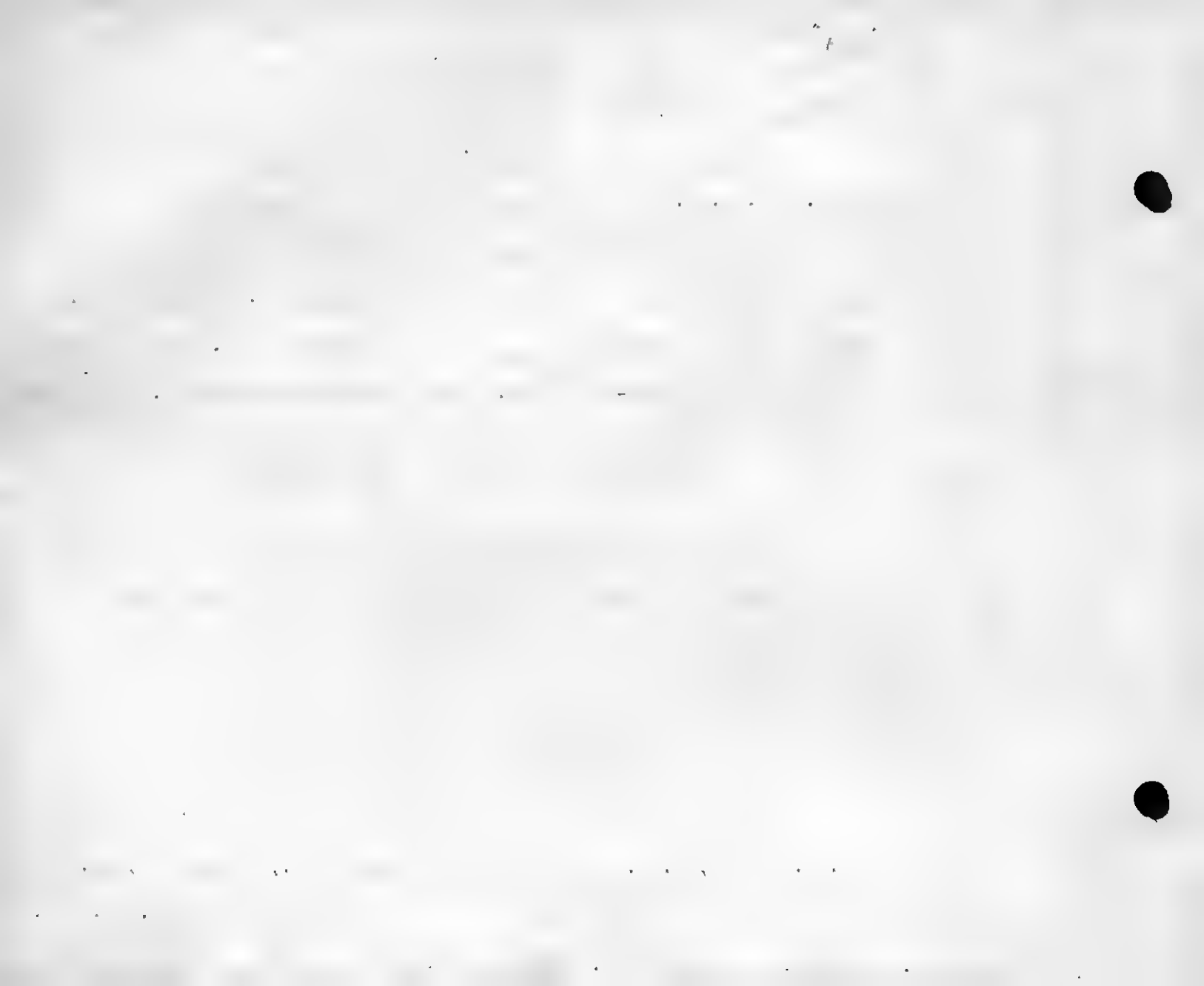


## CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print)		First Daisy	Middle Catherine	Last Hartle	2a. DATE OF DEATH Month 3, Day 1968		2b. HOUR 8:00P M
3. SEX Female		4. RACE White		5. DATE OF BIRTH Dec. 31, 1891		6. AGE (in years last birthday) 78 YRS.	
7a. BIRTHPLACE (State or foreign country) Hagerstown, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Williamsport		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Williamsport Sanitarium		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Practical Nurse		12b. KIND OF BUSINESS OR INDUSTRY Nursing	
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER 232 E. Washington St.		14. FATHER'S NAME First Middle Last Barry Hartle		15. MOTHER'S MAIDEN NAME First Middle Last Margaret E. Showe			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) No.		16b. SOCIAL SECURITY NO. 215-26-2261		17. INFORMANT Address Md. Mr. Clyde R. Miller 249 Mill St. Hagerstown			
18. CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>May 8</u> , 19 <u>68</u> , to _____, 19____, that (I) (we) last saw the deceased alive on <u>May 8</u> , 19 <u>68</u> , and that in (my) (our) apinian death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>S. E. Rosillo</u>		22c. DATE SIGNED 6-5-68		22d. PHYSICIAN'S NAME (Type) F. E. Rosillo, M. D.			
22e. ADDRESS 580 Northern Ave., Hagerstown, Md.		22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-6-68		23c. NAME OF CEMETERY OR CREMATORY Manor Cemetery		23d. LOCATION (City or Town) (County) (State) Tilghmanton, Wash. Co., Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		24a. REC'D BY REGISTRAR JUN 10 1968		24b. REGISTRAR'S SIGNATURE Charles Judge			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1 DECEASED NAME (Type or print) <sup>First</sup> Hazel <sup>Middle</sup> Catherine <sup>Last</sup> Hastings			2a. DATE OF DEATH Month <u>June</u> Day <u>5</u> Year <u>1968</u>			2b. HOUR <u>7:30AM</u>				
3 SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>11/8/06</u>		6. AGE (In years last birthday) <u>61</u> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u> HOURS <u>  </u> MIN. <u>  </u>		
7a. BIRTHPLACE (State or foreign country) <u>Maryland</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>WASHINGTON</u>				
10. CITY OR TOWN OF DEATH <u>HAGERSTOWN</u>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>WESTERN MD. STATE HOSPITAL</u>			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <u>House Wife</u>			12b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>			13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>14 Snyder Avenue</u>	
14. FATHER'S NAME <sup>First</sup> Albert <sup>Middle</sup> <sup>Last</sup> Mellette			15. MOTHER'S MAIDEN NAME <sup>First</sup> Georgetta <sup>Middle</sup> <sup>Last</sup> Long							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <u>no</u> or (unknown)			16b. SOCIAL SECURITY NO <u>None</u>			17. INFORMANT Address <u>David E. Hastings 14 Snyder Ave. Hagerstown, Md.</u>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>Arterial Hypotension</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Adrenal insufficiency</u>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>unknown</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>19</u>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>April 4, 1968</u> , to <u>June 5, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 5, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Fe U. Porciuncula M.D.</u>						DEGREE <u>M.D.</u>		22c. DATE SIGNED <u>June 5, 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>Fe U. Porciuncula, M.D.</u>						22e. ADDRESS <u>Western Maryland State Hospital</u>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE <u>June 7, 1968</u>			23c. NAME OF CEMETERY OR CREMATORY <u>St. Pauls Cemetery</u>			23d. LOCATION (City or Town) (County) (State) <u>Near Clearspring, Md.</u>	
24. FUNERAL DIRECTOR <u>Andrew K. Coffman Funeral Home Inc.</u>						25a. REC'D BY REGISTRAR DATE <u>JUN 7 1968</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		

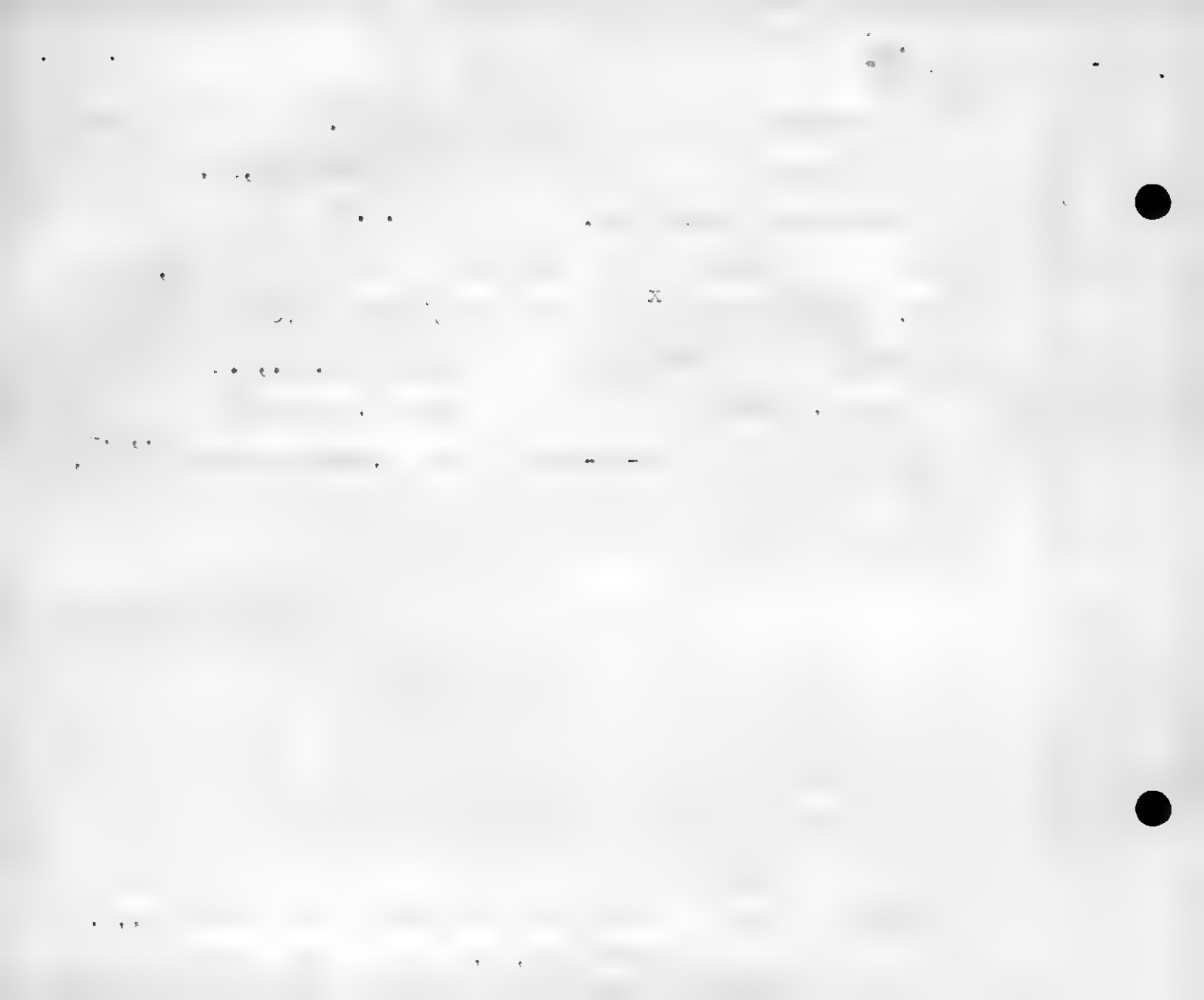


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

1 PLACE OF DEATH a. COUNTY <b>Washington</b> MARYLAND		2 USUAL RESIDENCE (Where deceased lived, if institution residence before admission) a. STATE <b>Penna.</b> b. COUNTY <b>Franklin</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hagerstown</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mercersburg, Pa. 17236</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hosp.</b>		d. STREET ADDRESS <b>R.D.2</b>	
3 NAME OF DECEASED (Type or print) <b>First ELVA Middle MAY Last HAWBAKER</b>		4 DATE OF DEATH Month <b>June</b> Day <b>30</b> Year <b>1968</b>	
5 SEX <b>Fem.</b>	6. COLOR OR RACE <b>White</b>	7 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8 DATE OF BIRTH <b>5/11/1892</b>
9 AGE (In years last birthday) yrs <b>76</b>		10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
10b KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11 BIRTHPLACE (County & State, or foreign country) <b>Mercersburg, Pa., R.1</b>	
12 CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>John C. Metcalfe</b>	
14. MOTHER'S MAIDEN NAME <b>Laura J. Clapsaddle</b>		15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>	
16 SOCIAL SECURITY NO <b>195-16-3719</b>		17 INFORMANT <b>Luther S. Hawbaker</b> Address <b>Pa., R.#2</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>4109 Acute Myocardial Infarction</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>4201 Arteriosclerotic Heart Disease</b> DUE TO (b) <b>not known</b> DUE TO (c) <b>not known</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) <b>Diabetes Mellitus</b>			
19 WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part or Part 1 of item 18)		20c TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	
20d INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f (City or town) (County) (State)		21. I certify that (I) (this hospital) attended the deceased from <b>May 31, 1968</b> to <b>6/30, 1968</b> , that (I) (we) last saw the deceased alive on <b>6/30, 1968</b> , and that death occurred at <b>2 A.M.</b> from causes and on the date stated above.	
22a SIGNATURE <b>A. M. RIEGO</b>		22b DATE SIGNED <b>7/1/68</b>	
22c PHYSICIAN'S NAME (Type) <b>A. M. RIEGO</b>		22d ADDRESS <b>119 E. Antietam, Hagerstown</b>	
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE THEREOF <b>7/3/68</b>	
23c NAME OF CEMETERY OR CREMATORY <b>Welsh Run Brethren</b>		23d LOCATION (City or Town) (County) (State) <b>Mercersburg, Pa., R.#2</b>	
24 FUNERAL DIRECTOR <b>T. M. Beninger</b>		25a REC'D BY REGISTRAR <b>WJL - 3 1968</b>	
25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c REGISTRAR'S NAME <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

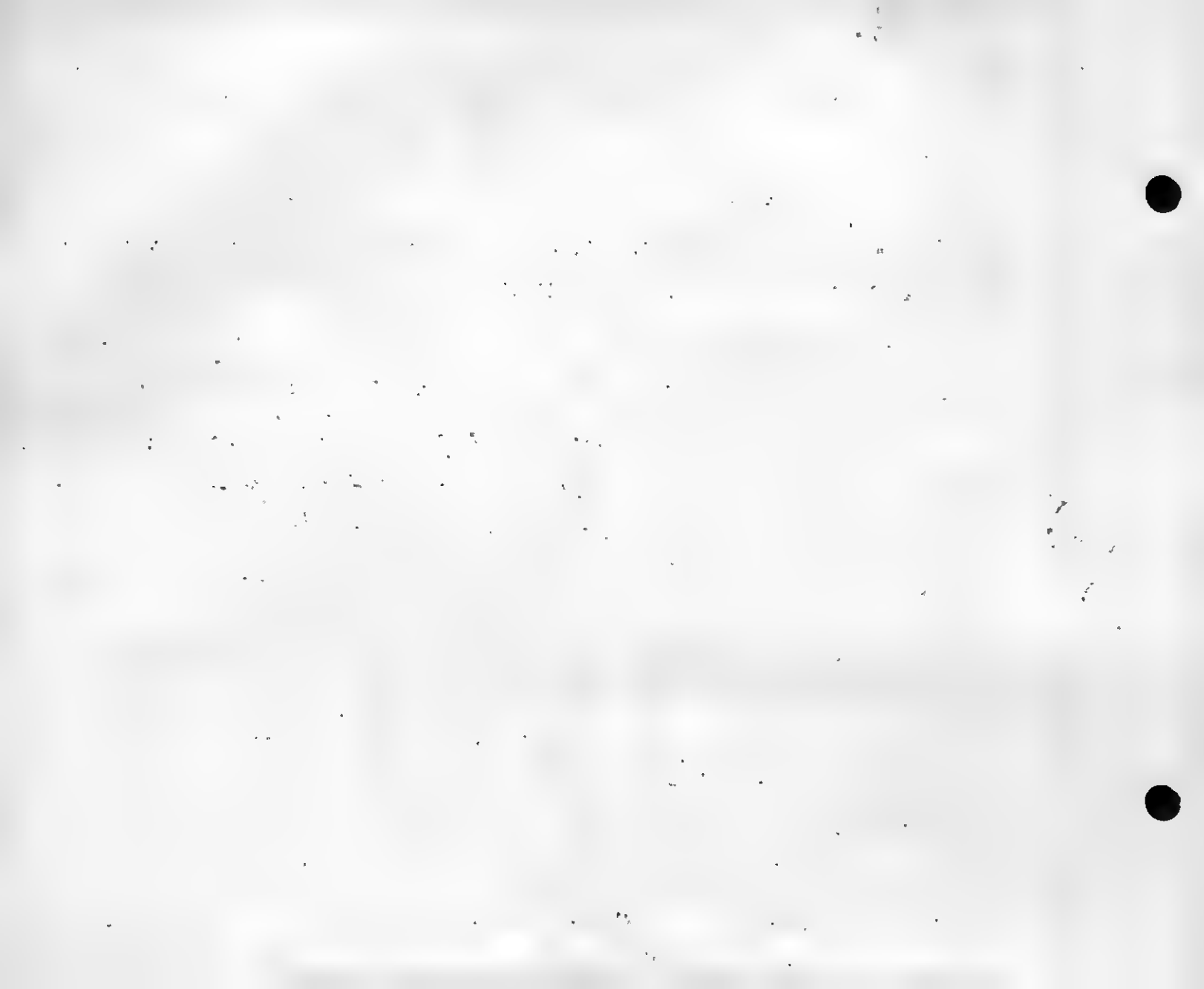




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First <b>JAMES</b>			Middle <b>WILLIAM</b>			Last <b>HEAD</b>		
2a. DATE OF DEATH			JUNE			Month 4 Day 68 Year			2b. HOUR 3 p M		
3. SEX <b>MALE</b>			4. RACE <b>WHITE</b>			5. DATE OF BIRTH <b>AUGUST 14, 1910</b>			6. AGE (In years and birthday) <b>58 YRS.</b>		
7a. BIRTHPLACE (State or foreign country) <b>TENNESSEE</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WASHINGTON</b>		
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON COUNTY</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>SHEET METAL WORKER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SANDBLAST MFG.</b>		
13a. USUAL RESIDENCE (Where deceased lived if institution Residence before admission) STATE <b>HAGERSTOWN</b>			13b. COUNTY <b>WASHINGTON</b>			13c. CITY OR TOWN <b>HAGERSTOWN</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>425 CLARENDON AVE.</b>			14. FATHER'S NAME First <b>JOSEPH</b>			Middle <b>HEAD</b>			15. MOTHER'S MAIDEN NAME First <b>ROSA</b>		
Middle <b>NELL</b>			Last <b>BEARD</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW 2</b>			16b. SOCIAL SECURITY NO <b>220-10-3089</b>		
17. INFORMANT <b>MRS. BONNIE K HEAD</b>			Address <b>425 CLARENDON AVE HAGERSTOWN, MD.</b>			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>Coronary artery Dis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>Arteriosclerotic Cardiovascular Dis.</b> (b) <b>Coronary artery Dis.</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic Cardiovascular Dis.</b> (c) <b>Arteriosclerotic Cardiovascular Dis.</b>			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>7 days</b> <b>years</b> <b>years</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Sincerely: Previous myocardial infarction, Aspiration pneumonia</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>2 Jan 68</b> to <b>date</b> , 19 <b>68</b> , that (I) <del>(was)</del> last saw the deceased alive on <b>4 June 19 68</b> and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(not)</del> view the body after death.											
22b. SIGNATURE <b>Richard T. Binford</b>			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <b>6/5/68</b>		
22d. PHYSICIAN'S NAME (Type) <b>RICHARD T. BINFORD, M.D.</b>			22e. ADDRESS <b>1135 POTOMAC AVE., HAGERSTOWN, MD.</b>			23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>			23b. DATE <b>6/8/68</b>		
23c. NAME OF CEMETERY OR CREMATORY <b>MONTE VISTA CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>JOHNSON CITY, WASHINGTON, TENN.</b>			24. FUNERAL DIRECTOR <b>Charles W. Reager</b>			25a. REC'D BY REGISTRAR <b>JUN 7 1968</b>		
25b. REGISTRAR'S SIGNATURE <b>Charles J. Judge</b>			25c. DATE <b>JUN 7 1968</b>			25d. ADDRESS <b>HAGERSTOWN, MD.</b>					



DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

..5101

1. DECEASED-NAME (Type or print) <b>Mary Elizabeth Hill</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>24</b> Year <b>1968</b>		2b. HOUR <b>6:50 p.m.</b>
3. SEX <b>Female</b>	4. RACE <b>Colored</b>	5. DATE OF BIRTH <b>Nov 13 1919</b>		6. AGE (In years last birthday) <b>48</b> YRS.	IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. DAYS HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Carlisle, Pa.</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>Hagerstown Md</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Domestic</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Private fam.</b>		13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	
13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIM TSP? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>	13e. STREET AND NUMBER <b>669 Forrest Dr.</b>		
14. FATHER'S NAME First <b>James</b> Middle <b>D</b> Last <b>Ramsey</b>		15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>B</b> Last <b>Dennis</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input type="checkbox"/>		16b. SOCIAL SECURITY NO <b>171-23-4182</b>		17. INFORMANT Address <b>Calvin R. Hill 669 Forrest Dr.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Metastatic brain tumor</b> <b>11-27</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Esthesioneuroblastoma</b> Conditions, if any, which gave rise to immediate cause (a), storing the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Approx. 3 mo.</b> <b>Eleven yrs.</b>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c) <b>11-27</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>February 18 1967</b> , to <b>June 24 1968</b> , that (I) <del>(was)</del> saw the deceased alive on <b>June 24 1968</b> , and that in (my) <del>(her)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(was)</del> (did) <del>(did not)</del> view the body after death.					
22b. SIGNATURE <b>Donald E. Martin M.D.</b>		22c. DATE SIGNED <b>6/25/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Donald E. Martin, M.D.</b>	
22e. ADDRESS <b>363 S. Cleveland Ave., Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-28-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown Md.</b>					
24. FUNERAL DIRECTOR <b>John R. Watson of Hagerstown Md</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print)			First	Middle	Last	2a DATE OF DEATH Month Day Year		2b HOUR			
William Maxwell Hungate						June 24, 1968		8A -M			
3. SEX		4. RACE		5. DATE OF BIRTH		6 AGE (In years last birthday)		7 UNDER 1 YEAR MONTHS DAYS			
male		white		9-26-1907		60 YRS					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Washington Md					
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY			
Hagerstown			1515 W. Church, St.			Switchboard Opera.		City, Gov.			
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY - MITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Md.			Wash.		Hagerstown				1515 W. Church, St.		
14 FATHER'S NAME			First	Middle	Last	15 MOTHER'S MAIDEN NAME			First	Middle	Last
Charles T. Hungate						Bessie Snyder					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17 INFORMANT			Address		
no			214-09-2607			Mrs. Helen M. Hungate			Hagerstown, Md.		
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>acute myocardial failure</u>									2-3 Wks		
DUE TO, OR AS A CONSEQUENCE OF (b) <u>arteriosclerotic cardiac Dis.</u>											
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. <u>42 yrs</u>									(c)		
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I <u>Rheumatic heart disease, aortic stenosis, Emphysema</u>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED Where <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>26 Dec 67</u> to <u>Inte</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>31 Mar 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE <u>Richard T. Binford, M.D.</u>						22c. DATE SIGNED 24 June 68					
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
Richard T. Binford, M. D.						1135 Potomac Ave., Hagerstown, Md.					
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c. NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)			
Burial			6-27-1968		Rose Hill Cemetery			Hagerstown, Md.			
24 FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home Hagerstown, Md.						JUN 27 1968		<u>Charles Judge</u>			



## CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) Charles Kendle Keadle			2a. DATE OF DEATH June 7 1968		2b. HOUR 6:30P M
3 SEX Male	4 RACE White	5 DATE OF BIRTH April 23, 1900		6 AGE (In years last birthday) 68 YRS.	IF UNDER 1 YEAR MONTHS 1 DAYS 14
7a. BIRTHPLACE (State or foreign country) Mapleville, Md.	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10 CITY OR TOWN OF DEATH Boonsboro Rfd. 2, Md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Clerk	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Hardware		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Boonsboro	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rfd. 2	
14 FATHER'S NAME First Middle Last James R. Keadle		15. MOTHER'S MAIDEN NAME First Middle Last Rosa Nunamaker			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or (unknown) No.		16b. SOCIAL SECURITY NO. 214-09-1366	17 INFORMANT Address Mrs. Pauline Keadle, Rfd. 2, Boonsboro, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF, (b) Arteriosclerotic heart disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes 10					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4301					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from 1958, to death, 19, that (I) (we) last saw the deceased alive on June 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.					
22b. SIGNATURE Robert T. Keadle		DEGREE ATTENDING PHYS	22c. DATE SIGNED 6-9-68	MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) Robert T. Keadle		22e. ADDRESS Hagerstown, Md.			
23a. BURIAL CREMATION REMOVAL (Specify) Burial	23b. DATE 6-10-68	23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md.	
24 FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		ADDRESS	25a. REC'D BY REGISTRAR JUN 12 1968	25b. REGISTRAR'S SIGNATURE John H. Bast, Jr.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove card paper 3, 4, 5, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) <i>Keller Daisy J. Keller</i>			2a. DATE OF DEATH Month <i>June</i> Day <i>13</i> Year <i>1968</i>			2b. HOUR <i>4 P.M.</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>February 23, 1889</i>		6. AGE (In years last birthday) <i>79</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <i>Frederick, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>United States</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.				
10. CITY OR TOWN OF DEATH <i>Williamsport, Md.</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Homewood Church Home, Inc.</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>housewife</i>			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institut on Residence before admission) STATE <i>Maryland</i>			13b. COUNTY <i>Washington</i>			13c. CITY OR TOWN <i>Middletown</i>			13d. INSIDE CITY, MTS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First <i>Silas</i> Middle <i>A.</i> Last <i>Thomas</i>			15. MOTHER'S MAIDEN NAME First <i>Katherine</i> Middle <i>Conrad</i> Last <i>Conrad</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)				
16b. SOCIAL SECURITY NO. <i>219-54-0855</i>			17. INFORMANT <i>Mark E. Wagner</i>			17a. ADDRESS <i>2750 Virginia Avenue, Williamsport, Md.</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i> <i>1651</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>C.A. of Hypertension</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>2 years</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>6 mos.</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>164x Hypertensive C.V. Dis.</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>65</i> , to <i>6-13</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>Robert P. Conrad</i>			DEGREE <i>M.D.</i>			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED <i>6-14-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Robert P. Conrad, M.D.</i>			22e. ADDRESS <i>137 W. Washington St., Hagerstown, Md.</i>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>burial</i>			23b. DATE <i>6/15/68</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Reformed Cemetery</i>			23d. LOCATION (City or Town) (County) (State) <i>Middletown, Fred., Md.</i>	
24. FUNERAL DIRECTOR <i>Gladhill Funeral Home, Middletown, Maryland</i>			25a. REC'D BY REGISTRAR DATE <i>JUN 18 1968</i>			25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>				

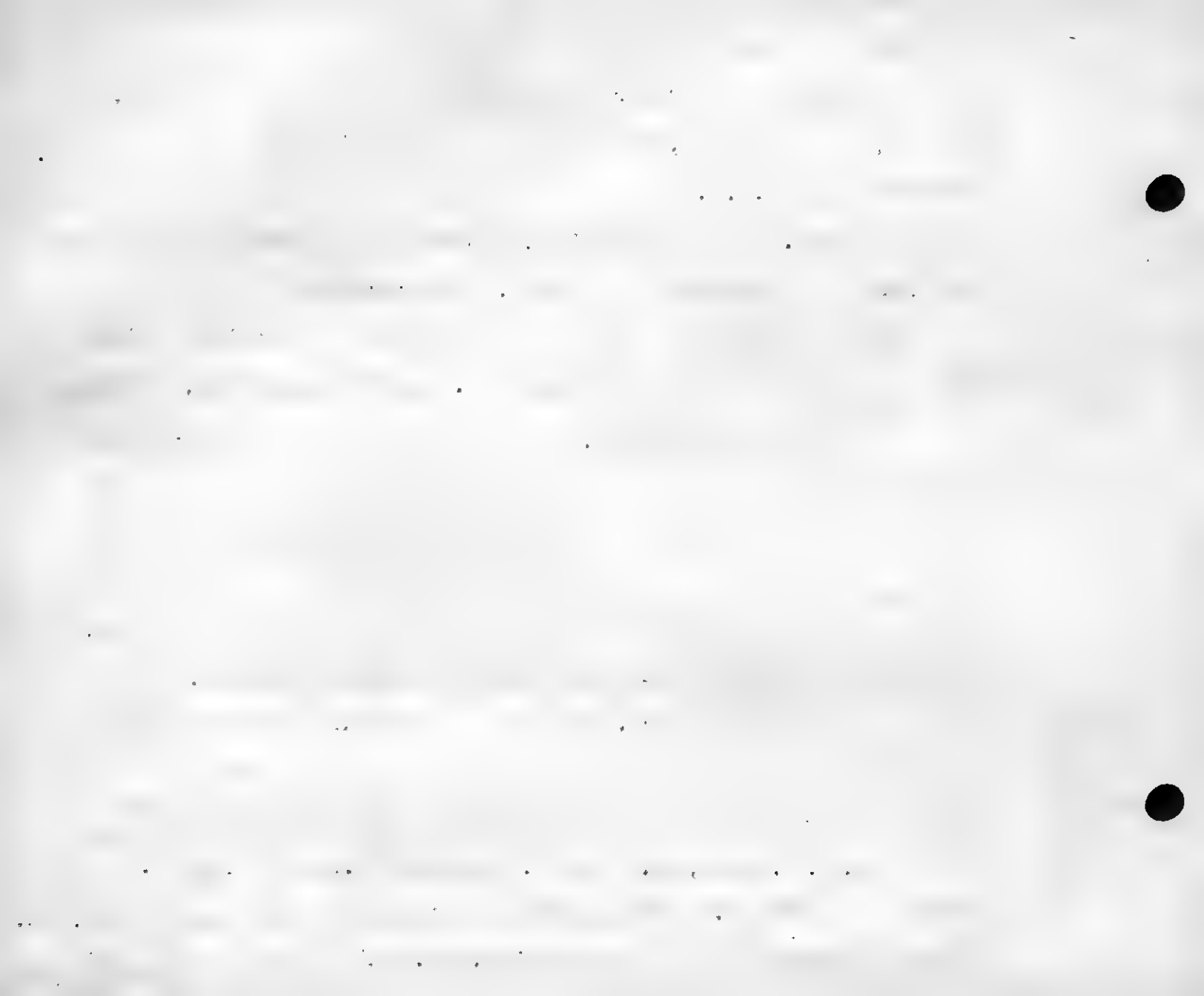


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. He pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)		First <b>David</b>		Middle <b>Luther</b>		Last <b>King</b>		2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> 2b HOUR <input type="checkbox"/> M <input type="checkbox"/> P	
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>April 15, 40</b>		6 AGE <b>28</b> YRS	IF UNDER 24 HRS MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c DATE PRONOUNCED DEAD <b>June 22</b> day Year <b>68</b>		7d HOUR <b>7:40</b> P. M
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			
10 CITY OR TOWN OF DEATH <b>Hagerstown Md.</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Concrete Mason</b>				12a USUAL OCCUPATION (Kind of work done during most of working life even if retired) <b>Masonry</b>		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if instituton Residence before death) <b>Maryland</b>		13b CITY OR TOWN <b>Washington</b>		13c RFD <b>2, Williamsport</b>		13d STREET AND NUMBER			
14. FATHER'S NAME First Middle Last <b>Harry Luther King</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Dorothy Louise Reed</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b SOCIAL SECURITY NO <b>219-36-3346</b>		17. INFORMANT ADDRESS <b>Mrs. Gloria King RFD2, Williamsport</b>					
18 CAUSE OF DEATH (Enter on y one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Drowning.</b> <b>800.0</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR COND TION GIVEN IN PART 1(a)									
19a DATE OF OPERATION				19b COND TION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>June 22- 19 68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fell from boat while fishing.</b>					
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Little Pool, 3 mi. East of</b>		21f LOCATION Street or R.F.D. No City or Town County State <b>Hancock, Washington, Maryland</b>					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>		EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22b. DATE SIGNED <b>June 24, 1968</b>		22c. DEPT. MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b DATE <b>June 25, 68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Cedar Lawn Memorial Park</b>		23d LOCATION (City or Town) (County) (State) <b>Hagerstown Wash. Md.</b>		23e REC'D BY REGISTRAR <b>J. Charles Judge</b>	
24. FUNERAL DIRECTOR <b>Thompson Funeral Home</b>		ADDRESS <b>Clear Spring, Md</b>		25a JUN 27 1968		25b REGISTRAR'S SIGNATURE			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First <i>William</i>	Middle <i>Edward</i>	Last <i>King, Jr.</i>	2a. DATE OF DEATH Month <i>June</i> Day <i>22</i> Year <i>1968</i>		2b. HOUR M <i></i>		
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>August 18, 1927</i>		6. AGE (In years last birthday) <i>40</i> YRS.		IF UNDER 1 YEAR MONTHS <i></i> DAYS <i></i> IF UNDER 24 HRS. HOURS <i></i> MIN. <i></i>		
7a. BIRTHPLACE (State or foreign country) <i>Hagerstown, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i>		Md <i></i>		
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>405 Ridge Ave.</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Foreman</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Shoe Mfg.</i>				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>405 Ridge Ave.</i>		
14. FATHER'S NAME First <i>William</i> Middle <i>Edward</i> Last <i>King, Sr.</i>			15. MOTHER'S MAIDEN NAME First <i>Ethel</i> Middle <i>Louise</i> Last <i>Fisher</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>Yes</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>220-16-3045</i>		17. INFORMANT <i>Mrs. Mary Jane Skipper</i>		Address <i>405 Ridge Ave.</i>		City <i>Hagerstown, Md.</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Congestive Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF 4 <i>Myocardopathy</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <i>4222</i> (b) <i>2 years</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i></i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i></i>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>GOUT</i>										
19a. DATE OF OPERATION <i></i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i></i>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i></i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. <i></i> Month <i></i> Day <i>19</i> Year <i></i> P.M. <i></i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <i></i>						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <i></i>			21f. LOCATION Street or R.F.D. No <i></i> City or Town <i></i> County <i></i> State <i></i>					
22a. I certify that (I) (this hospital) attended the deceased from <i>1/10</i> , 19 <i>68</i> , to <i>6/14/68</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6/14</i> , 19 <i>68</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <i>A. Mandell, M.D.</i>					DEGREE <i></i> ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>6/24/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>ANDREW M. MANDELL, M.D.</i>					22e. ADDRESS <i>301 E. ANTIETAM ST. HAGERSTOWN, MARYLAND</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>6/25/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington Md.</i>				
24. FUNERAL DIRECTOR <i>Wm. G. Horst</i> <i>Rest Haven Funeral Chapel</i>					ADDRESS <i>Hagerstown, Md.</i>		25a. REC'D BY REG. STRAR <i>JUN 26 1968</i>		25b. REG. STRAR'S SIGNATURE <i>Charles Judge</i>	

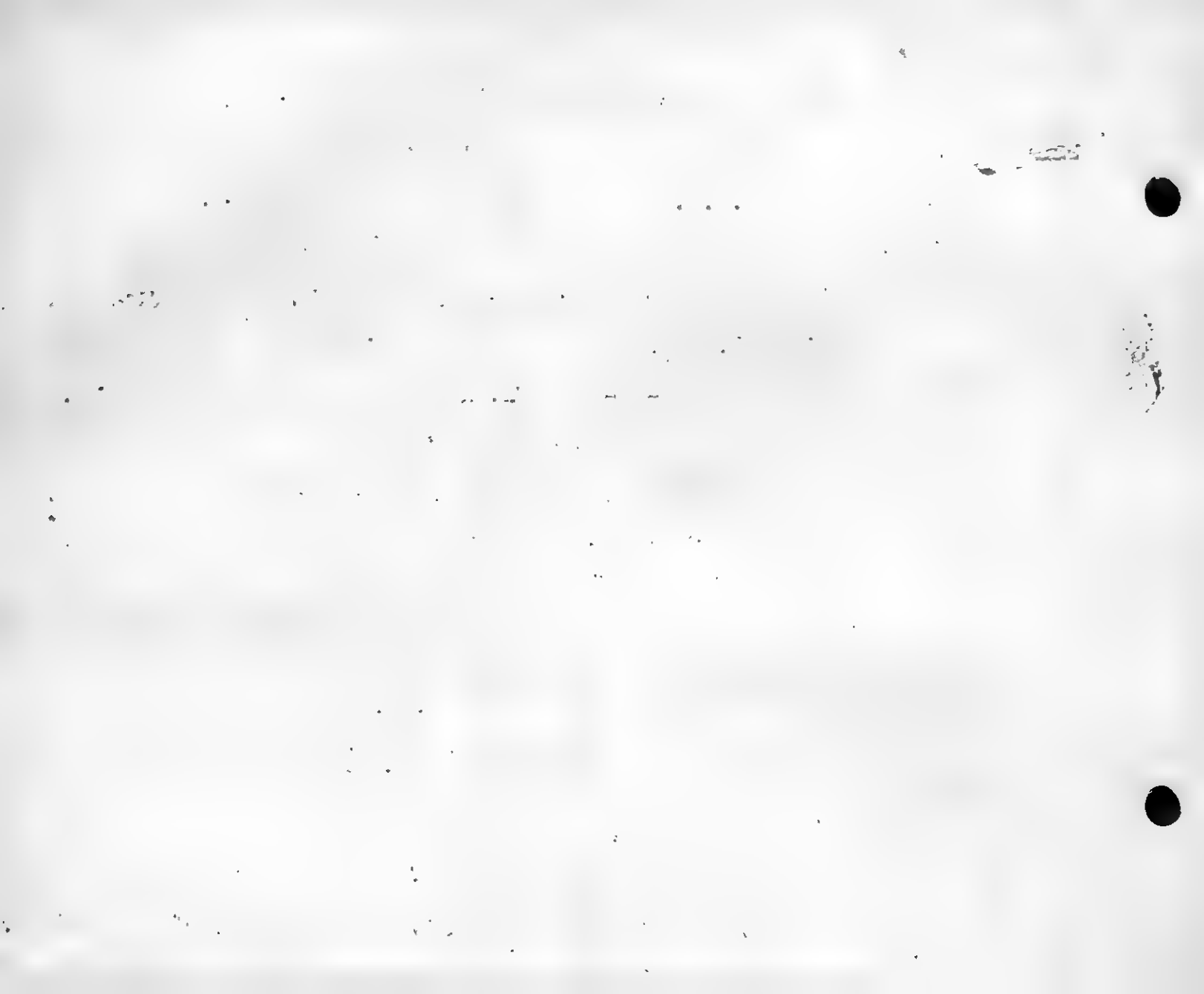


CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>CARL</b> <sup>First</sup> <b>BORDNER</b> <sup>Middle</sup> <b>KLOCK</b> <sup>Last</sup>			2a. DATE OF DEATH <b>JUNE</b> Month <b>26</b> Day <b>1968</b>			2b. HOUR <b>5:05</b> <sup>P</sup> <sup>M</sup>				
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5. DATE OF BIRTH <b>10/31/1882</b>		6. AGE (In years last birthday) <b>85</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>PENNSYLVANIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>			Md	
10. CITY OR TOWN OF DEATH <b>WILLIAMS PORT</b>		11. NAME OF HOSPITAL OR street address <b>WILLIAMS PORT</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED WATCH MAKER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>SHOP</b>				
13a. USUAL RESIDENCE (Where deceased lived, if admission) <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13e. STREET AND NUMBER <b>RT. #1 HAGERSTOWN MD.</b>		
14. FATHER'S NAME <sup>First</sup> <b>JOSEPH</b> <sup>Middle</sup> <b>S.</b> <sup>Last</sup> <b>KLOCK</b>			15. MOTHER'S MAIDEN NAME <sup>First</sup> <b>CATHERINE</b> <sup>Middle</sup> <b>ANN</b> <sup>Last</sup> <b>BORDNER</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		16b. SOCIAL SECURITY NO. <b>215-20-9642</b>		17. INFORMANT Address <b>MR. RONALD KLOCK HAGERSTOWN MD.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia RLL</b> <b>4</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost <b>And Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF <b>(c) Coronary heart disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 days</b> <b>indefinite</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>4</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>9-19</b> , 19 <b>61</b> , to <b>death</b> , that (I) (we) lost saw the deceased alive on <b>6-26</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.										
22b. SIGNATURE <b>Robert F. Keadle</b>		DEGREE <b>Robert F. Keadle</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6-28-68</b>				
22d. PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b>		22a. ADDRESS <b>Hagerstown, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>6/29/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>LUTHERN &amp; REFORMED CHURCH</b>		23d. LOCATION (City or Town) (County) (State) <b>URBAN PENNA.</b>				
24. FUNERAL DIRECTOR <b>W. J. Horne</b>		ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>111 - 1 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

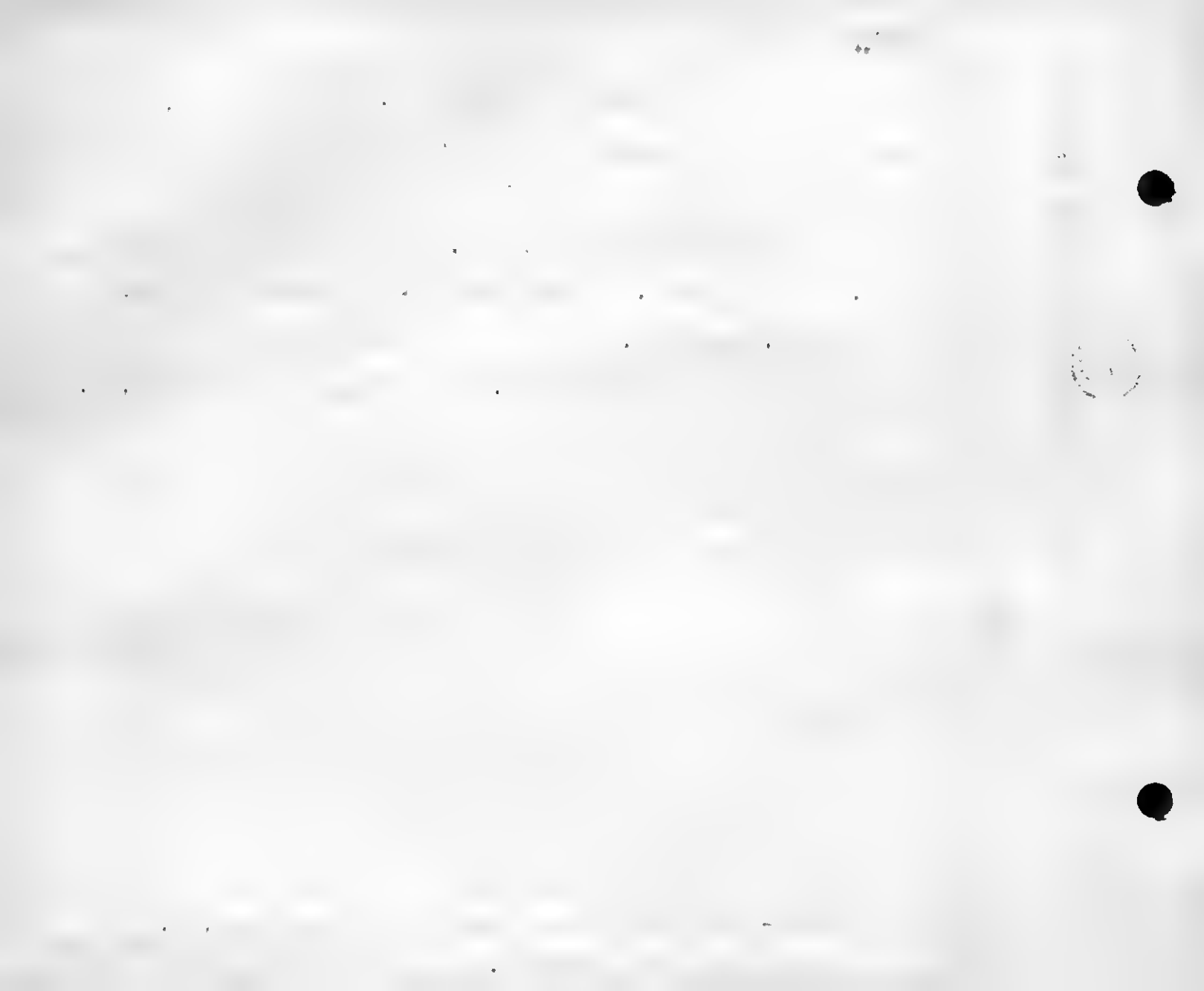
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09103

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
Frank Emerson Knapp Jr.						June 20, 1968			2 a.m.		
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS.	
male		white		7-12-1916		51 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			Md.		
Pennsylvania		USA				Washington					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown		1020 Columbia, Road.		Clerk		Railroad					
13a. USUA. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER			
Md.		Wash.		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1020 Columbia, Road			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Frank E. Knapp Sr.						Mary Suttcliff					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
Yes		WW II		214-09-2378		Mrs. Anna Lee Knapp Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF Atherosclerotic coronary disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) sev. yrs. (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
										sudden	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
42.1											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from Feb. 19 59, to June 19 68, that (I) (we) lost the deceased alive on 5/1/19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Howard N. Weeks, M.D.		6/21/68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
		580 Northern Ave., Hagerstown, Md.									
23a. BURIAL, CREMAT. ON, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		6-22-1968		Rest Haven Cemetery		Hagerstown, Md.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Minnich Funeral Home Hagerstown, Md.				DATE JUN 24 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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104  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) First Middle Last <b>William Frank Kooken</b>			2a DATE OF DEATH Month Day Year <b>June 19, 1968</b>		2b HOUR <b>2:20 A.M.</b>
3 SEX <b>male</b>	4 RACE <b>white</b>	5. DATE OF BIRTH <b>April 7, 1880</b>		6 AGE (In years Month Day YRS. <b>88</b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. COUNTY OF DEATH <b>Washington</b>		Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Avalon Manor Nurs H.</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Carpenter</b>	
12b KIND OF BUSINESS OR INDUSTRY <b>Construction</b>					
13a USUAL RESIDENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>	
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>10 E. Baltimore St.</b>			
14. FATHER'S NAME First Middle Last <b>Issac Kooken</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Alice Kight</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b SOCIAL SECURITY NO (If yes give war or dates of service) <b>215-14-6384</b>		17 INFORMANT Address <b>Mrs. Laura Kooken, Hagerstown, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerosis Generalized.</b> DUE TO, OR AS A CONSEQUENCE OF (c) 4559 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days.</b> <b>2 hrs +</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 18, 1968</b> , to <b>June 19, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 18, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Charles A. Hoffman</b>		DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>6/19/68</b>	
22d PHYSICIAN'S NAME (Type) <b>Dr. A. Hoffman</b>		22e. ADDRESS <b>214 N. Pot. St. Hagerstown, Md.</b>			
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>6-21-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Philos Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Westernport, Md.</b>	
24. FUNERAL DIRECTOR <b>Boal's Funeral Service,</b>		ADDRESS <b>Westernport, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 24 1968</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 48

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print)		First <b>LILLIAN</b>	Middle <b>BARR</b>	Last <b>KRIDLER</b>	2a. DATE OF DEATH <b>JUNE</b> Month <b>5</b> Day <b>1968</b> Year		2b. HOUR <b>3 A</b> M				
3 SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>1/14/1898</b>		6 AGE (In years last birthday) <b>70</b> YRS.		7 UNDER 1 YEAR MONTHS DAYS HOURS MIN		8 UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH <b>WASHINGTON</b>					
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital) <b>WASHINGTON CO. HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of last year) <b>SEAMSTRESS DRESS SHOP</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>MD</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>258 S. LOCUST ST.</b>			
14. FATHER'S NAME <b>HARVEY</b>		First <b>D.</b>		Middle <b>KRIDLER</b>		15. MOTHER'S MAIDEN NAME <b>IDA</b>		First <b>VIRGINIA</b>		Middle <b>CHAPMAN</b>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>NO</b>		(If yes give year or dates of service)		16b. SOCIAL SECURITY NO. <b>71429-3355</b>		17 INFORMANT <b>MR. ROBERT D. KRIDLER</b>		Address <b>HAGERSTOWN MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>4109</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>5 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>May 29</b> , 19 <b>67</b> , to <b>June 5</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>June 5</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (we) (did not) view the body after death.											
22b. SIGNATURE <b>David A. Hoffman</b>		DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>6/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>David A. Hoffman</b>		22e. ADDRESS <b>214 N. Potomac St. Hagerstown, Md.</b>									
23a. BURIAL, CREMATION, or other disposition of body <b>BURIAL</b>		23b. DATE <b>6/6/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>					
24. FUNERAL DIRECTOR <b>W. J. Norman</b>				ADDRESS <b>Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>JUN 10 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. Jager</b>			



# FOR STATE HEALTH DEPT.

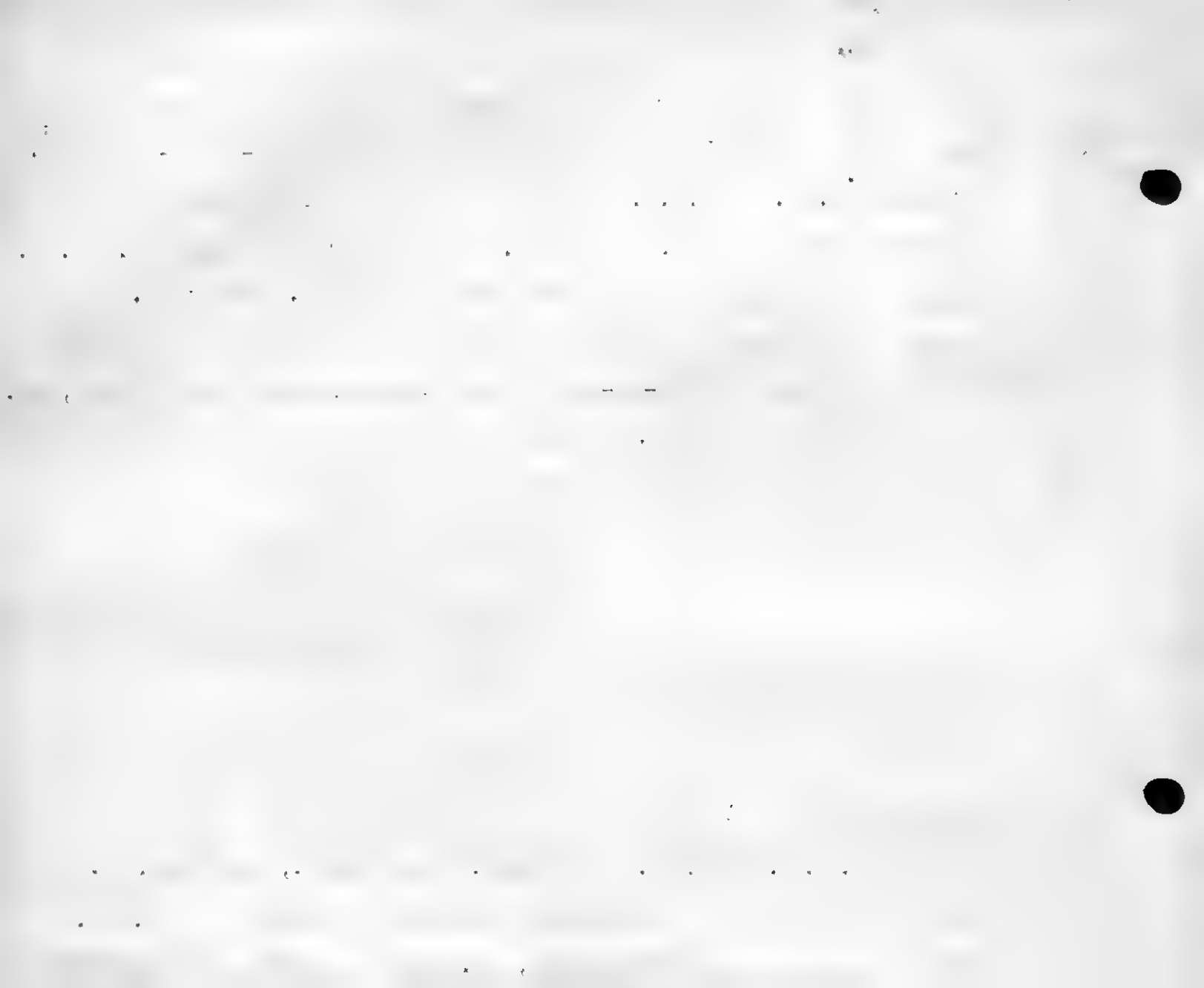
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

1-19-68, mt 22a film 401 Maryland State Department of Health  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Irvin Martin Lee						June 1 19 68			M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years as of birthday)	IF UNDER 1 YEAR MONTHS DAYS		F UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			6:10 P. M.
Male	White	7/18/17	50 YRS					Month 6- Day 1- Year 1968			P. M.
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH		
Hampshire W.VA.			U.S.A.						Washington Md		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Clear Spring			N. Martin St.			Railroad carman			W. Md. R.R.		
13a. USUAL RESIDENCE (Where deceased lived, if institution on: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. STREET AND NUMBER		
Maryland			Washington			Clear Spring			N. Martin St.		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
John Santa Lee			Lillie # Wilkens								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			None			236-20-9427			Patsy Darlene Lee Clear Spring, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Pending/ Acute Hemorrhagic Pancreatic Necrosis recent											
DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 5870											
(b) Acute Hemorrhagic Duodenopathy, Diffuse											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
Acute Ethanol Intoxication											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
				19							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED			
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER				6-3-68			
Dr. E. W. Ditto, Jr.				DEPUTY MEDICAL EXAMINER				25b. REGISTRAR'S SIGNATURE			
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
Burial				6/5/68				Greenlane Cemetery			
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			
Margaret Rowland				DATE JUN 5 1968				Charles Judge			
Clear Spring, Md.											

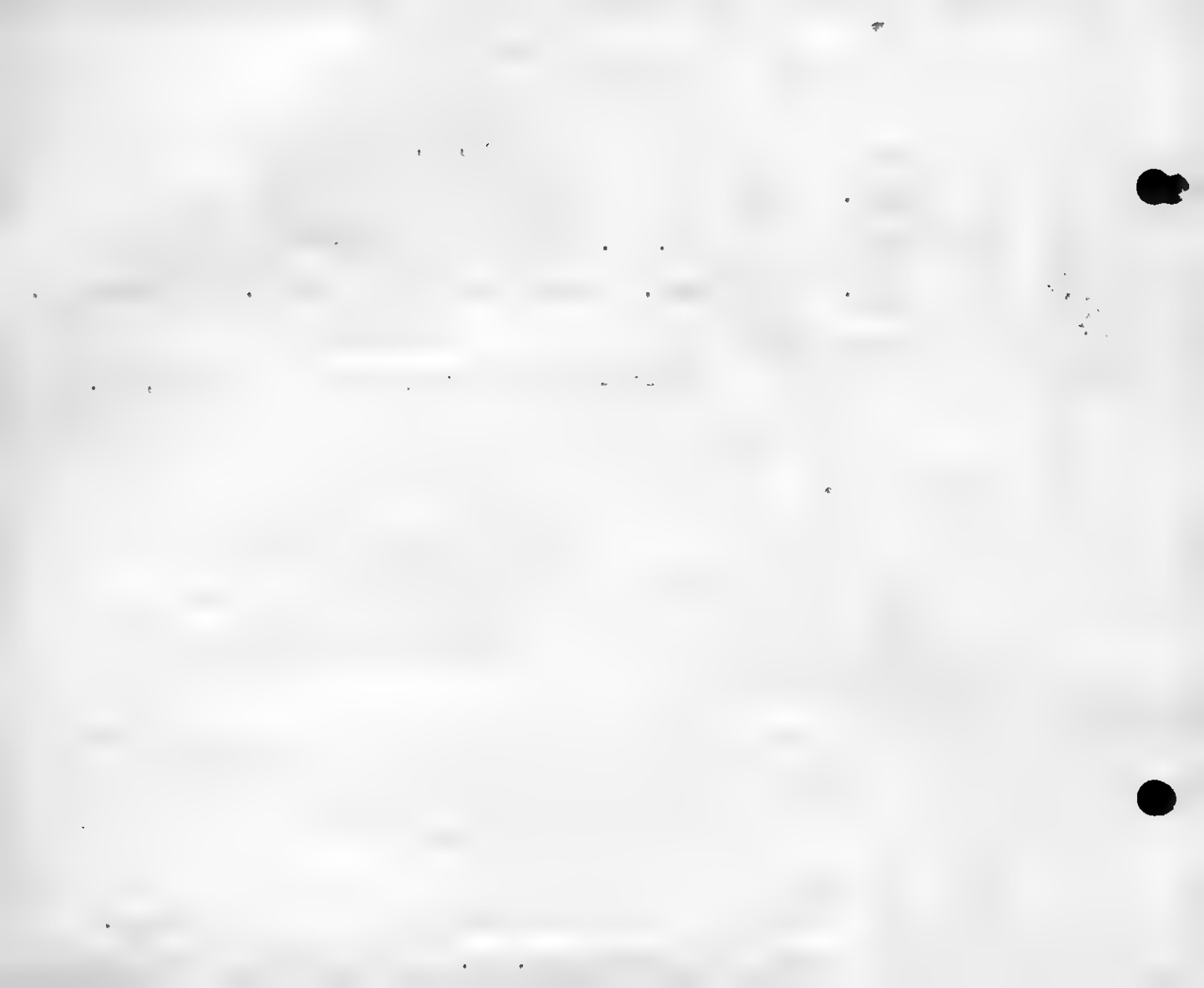




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician or duly qualified person, it should be detached for use as the burial-transit permit. Then please return the carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Edna			Ruth Linn			6 Month 1 Day 68 Year			5:20 M
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
female		white		Oct, 26, 1895		72 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		UAS				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Wash. Co. Hospital		processor		Gar depot			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.		Wash.		Hagerstown				108 E. Washington St.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last					
Daniel Gamble				Anna Sutton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address			
No		173-14-1695A		Alvin Linn		Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <i>liver metastasis</i>									
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>1538</i>									
(b) <i>Carcinoma of Colon</i>									
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
<i>Diabetes Mellitus, Generalized arteriosclerosis</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>5/26/1968</i> , to <i>6/1/1968</i> , that (I) (we) last saw the deceased alive on <i>5/31/1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Wm O. Ryals</i>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>6/3/68</i>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6-5-68		Pine Grove Cemetery		Neelyton Penna.			
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Minnich Funeral Home				Hagerstown, Md.		JUN 4 1968		<i>Charles Yunge</i>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 574  
304 REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

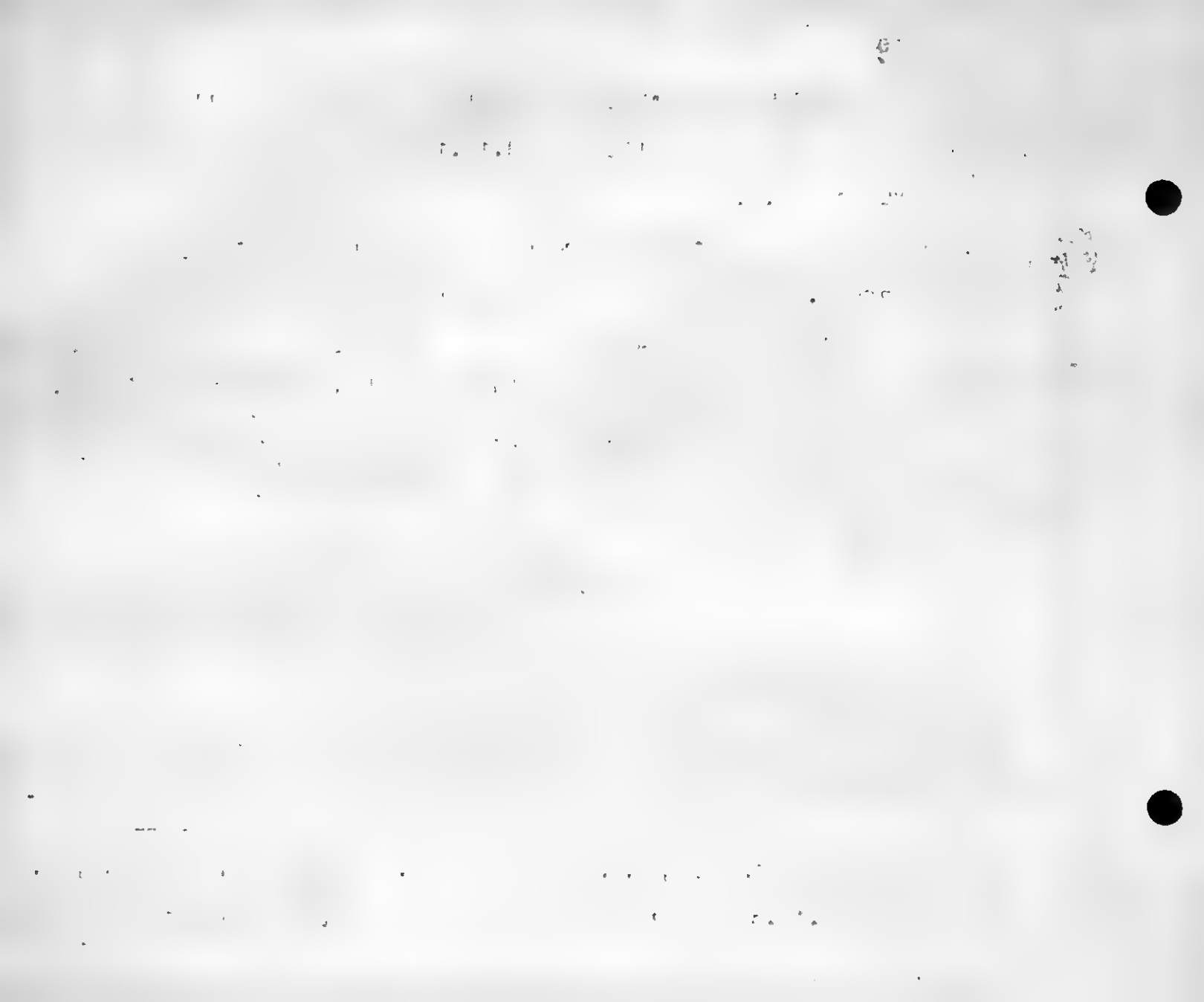
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR MINS		
Susan Jane Main						June 30 1968			6:00P		
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
Female		White		Dec. 6, 1880		87 YRS		6 24			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Middletown, Md.		U. S. A.				Washington		Md.			
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY					
Hagerstown		Washington Co. Hospital		Housewife		Own Home					
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER			
Maryland		Washington		Keedysville				Rfd. 1			
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
Henry Kephart						Francis Younkins					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service)			16b SOCIAL SECURITY NO.		17 INFORMANT		Address				
No.			None		Mrs. Welty Nicodemus		Rfd. 1, Keedysville, Md.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> DUE TO, OR AS A CONSEQUENCE OF <u>generalized arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>years</u> (b) <u>years</u> DUE TO, OR AS A CONSEQUENCE OF <u>years</u> (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertension</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1968</u> , to <u>June 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (aid) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED				22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS			
<u>Joseph Secondari</u>		7-1-68				Joseph Secondari, M.D.		21 N. Main St., Boonsboro, Md.			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		7-3-68		Boonsboro Cemetery		Boonsboro, Wash. Co., Md.					
24. FUNERAL DIRECTOR						25a RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr. 1112 N. Main St. Boonsboro, Md.						JUL - 5 1968		<u>Charles Judge</u>			



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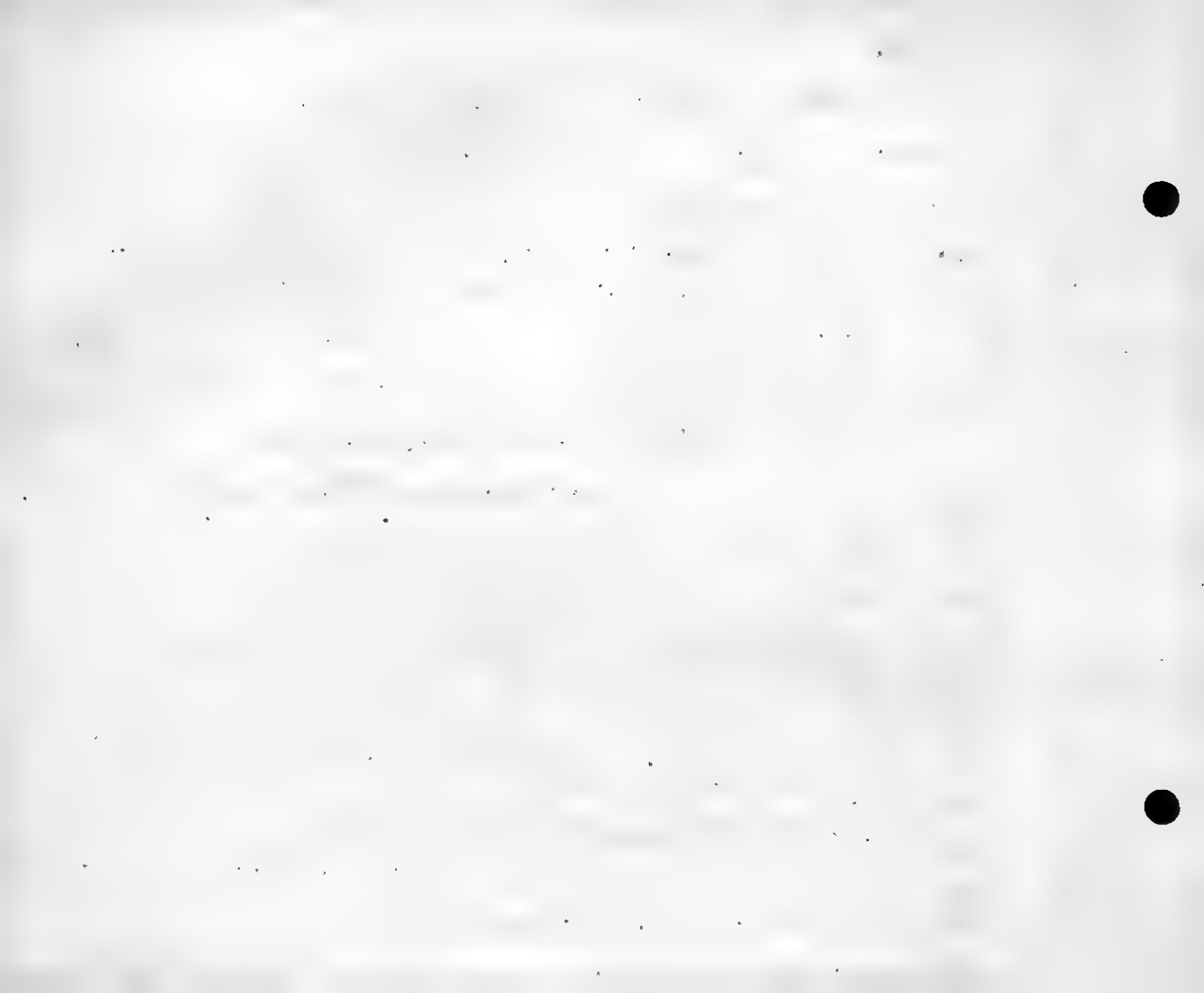
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
RUSSELL			STANLEY			MANNING			6 Month 11 Day 68 Year	
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
MALE		WHITE		3.18.1895		73 YRS.				
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
MARYLAND		U.S.A.				WASHINGTON Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
HAGERSTOWN			WASHINGTON COUNTY			FARMING (RETIRED)				
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?		13e STREET AND NUMBER	
PENNA.			FULTON		WARFORDSBURG PA		<input type="checkbox"/>			
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
CHARLES			MANNING			CARRIE MCULLOUGH				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.		17 INFORMANT Address					
NO			NONE		VIDA L MANNING WARFORDSBURG PENNA.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Rupture of aneurysm of Mt. Aorta artery</i>										
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										
(b) <i>Generalized arteriosclerosis</i>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)										
<i>Arteriosclerotic Heart Disease</i>										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Port 2, Item 18)						
		HOUR A.M. Month Day Year P.M. 19								
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION		Street or R.F.D. No.		City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <i>Jan</i> , 19 <i>62</i> , to <i>June</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>June 11</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE		DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED		
<i>Edson B. Moody</i>				<input checked="" type="checkbox"/>				6-14--68		
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS								
Edson B. Moody, M.D.		363 S. Cleveland Ave. Hagerstown, Md.								
23a. BURIAL, CREMATION, REMAINS		23b. DATE		23c. NAME OF CEMETERY OR CREMATOR		23d LOCATION (City or Town) (County) (State)				
BURIAL		6.15.68		PRESBYTERIAN		WARFORDSBURG FULTON PENNA				
24 FUNERAL DIRECTOR				ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE		
<i>Howard &amp; Elmore Hancock Inc</i>						DATE JUN 19 1968		<i>James J. Jones</i>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>Leila</b> <sup>First</sup> <b>GAYNELL</b> <sup>Middle</sup> <b>MARTIN</b> <sup>Last</sup>			2a. DATE OF DEATH <b>June</b> Month <b>23</b> Day Year <b>1968</b>			2b. HOUR <b>M</b>					
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Jan. 7 1925</b>		6. AGE (in years last birthday) <b>43</b> YRS.		7. IF UNDER 1 YEAR MONTHS <b>5</b> DAYS <b>15</b>		8. IF UNDER 24 HRS HOURS <b>24</b> MIN <b>00</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Washington</b> <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> <b>Md.</b>					
1d. CITY OR TOWN OF DEATH <b>Hagerstown</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Bookkeeper</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Auto Parts</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE <b>Maryland</b>			13b. COUNTY <b>Washington</b>			13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD #4</b>	
14. FATHER'S NAME <b>Peter</b> <sup>First</sup> <b>L</b> <sup>Middle</sup> <b>Martin</b> <sup>Last</sup>			15. MOTHER'S MAIDEN NAME <b>Helen</b> <sup>First</sup> <b>Shank</b> <sup>Middle</sup> <b>Shank</b> <sup>Last</sup>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>215-20-7817</b>			17. INFORMANT <b>Mr. David H. Martin</b> <b>Hagerstown Md.</b> <b>RFD #4</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Terminal carcinoma</b> <b>1830</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) <b>Carcinoma of the ovary</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>4 mos.</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <b>2/15</b> , 19 <b>68</b> , to <b>6/24</b> , 19 <b>68</b> , that <del>(I)</del> (we) lost saw the deceased alive on <b>6/23</b> , 19 <b>68</b> , and that in <del>(my)</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>(I)</del> (we) <del>(did)</del> (did not) view the body after death.											
22b. SIGNATURE <b>Thomas V Craig</b>				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/24/68</b>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS <b>247 N POTOMAC Hagerstown</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cemetery Mt. Taber Lutheran Church</b>			23d. LOCATION (City or Town) (County) (State) <b>Fairview Maryland</b>				
24. FUNERAL DIRECTOR <b>Albert L. Leaf</b>				ADDRESS <b>Williamsport Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			





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VR 115  
30M REV. 7-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Lottie See McConnell</b>			2a DATE OF DEATH <b>June</b> Month <b>19</b> Day <b>1968</b> Year			2b HOUR <b>9 32</b> AM			
3 SEX <b>Female</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>12/17/00</b>		6 AGE (in years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a BIRTHPLACE (State or foreign country) <b>West Virginia</b>		7b CIT. ZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>WASHINGTON</b> Md.			
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital during last of working life, even if retired) <b>WESTERN MD. STATE HOSPITAL</b>		12a USUAL OCCUPATION (Kind of work done during last of working life, even if retired) <b>Worked in factory</b>		12b KIND OF BUSINESS OR INDUSTRY <b>shoe</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Hagerstown</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>Hebb Rd. - Rt. #3</b>	
14. FATHER'S NAME First Middle Last <b>Scott</b> <b>Wm</b> <b>Barnes</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Dolly</b> <b>Virginia</b> <b>Rockwell</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown		16b SOCIAL SECURITY NO. <b>214-09-3043A</b>		17 INFORMANT <b>Mr. C.E. McConnell R #3</b>		Address <b>Hagerstown, Md.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast</b> DUE TO, OR AS A CONSEQUENCE OF: (b) <b>Carcinoma of the breast</b> DUE TO, OR AS A CONSEQUENCE OF: (c) <b>170x</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 yrs</b> <b>unknown</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral Embolism</b>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>February 19 1968</b> to <b>June 19 1968</b> , that (I) (we) lost the deceased alive on <b>June 19 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Fe U. Porciuncula M.D.</b>				22c. DATE SIGNED <b>6/19/68</b>		22d. PHYSICIAN'S NAME (Type) <b>Fe U. Porciuncula, M.D.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/23/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Hagerstown-Washington-Md.</b>			
24 FUNERAL DIRECTOR <b>Wm. C. Horst</b> <b>Rest Haven Funeral Chapel Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <b>Moses C. McMurry</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>11:55 A.M.</b>				
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 10, 1909</b>		6. AGE (In years last birthday) <b>58</b>		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN <b>0</b>		
7a. BIRTHPLACE (State or foreign country) <b>Liberal, Ka.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b>				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Baker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Bakery</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md.</b>			13b. COUNTY <b>Allegany</b>		13c. CITY OR TOWN <b>Cumberland</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>Jane Frazer Village</b>	
14. FATHER'S NAME First <b>James</b> Middle <b>O.</b> Last <b>McMurry</b>			15. MOTHER'S MAIDEN NAME First <b>M. Bertha</b> Middle <b>Blank</b> Last <b>Blank</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>212-22-6599</b>		17. INFORMANT Address <b>Mrs. Vera Davis, Cumberland, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> <b>4367</b> DUE TO, OR AS A CONSEQUENCE OF <b>CVA</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>CVA</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>10 mon</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>331X Pulmonary infarct</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>Edwin G. Riley MD</b>		22c. DATE SIGNED <b>21 June 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Edwin G. Riley MD</b>		22e. ADDRESS <b>1500 Penna., Hagerstown, Md.</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 24, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Cumberland, Allegany, Md.</b>				
24. FUNERAL DIRECTOR <b>James F. Scarpelli, Cumberland, Md.</b>				25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>JUN 25 1968</b>		



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 1043. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print) <b>Marv Leona Merriman</b>				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> Month <b>6</b> Day <b>5</b> Year <b>1968</b>				2b. HOUR <b>7:50</b> P.M.	
3. SEX <b>F.</b>	4. RACE <b>W.</b>	5. DATE OF BIRTH <b>2/11/25</b>	6. AGE (in years last birthday) <b>43</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	2c. DATE PRONOUNCED DEAD Month <b>6</b> Day <b>5</b> Year <b>1968</b>			2d. HOUR <b>7:50</b> P.M.
7a. BIRTHPLACE (State or foreign) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington Co. Hosp.</b>				12a. OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b> COUNTY <b>Fredrick</b>				13c. CITY OR TOWN <b>Brunswick</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>600 Second Ave.</b>	
14. FATHER'S NAME First <b>Martin</b> Middle <b>Greenfield</b> Last <b>Greenfield</b>				15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>Wenner</b> Last <b>Wenner</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown) <b>no</b>				16b. SOCIAL SECURITY NO <b>unknown</b>		17. INFORMANT <b>Malinda L. Cook, Brunswick, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Lobular Pneumonia</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>219.9</b> (b) <b>Multiple Rib Fractures &amp; Hemo-</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>pneumothorax - Fracture pelvis + tibia</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3-5 days</b> <b>10 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>225.4</b>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <b>6-22-68</b> P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <b>Auto Accident</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Street</b>		21f. LOCATION Street or R.F.D. No <b>Charles town</b>		City or Town <b>Jeff.</b>		County <b>W.Va.</b>	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Edward W. Ditto III</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED <b>6-5-68</b>	
EXAMINER'S NAME (Type) <b>Dr. Edward W. Ditto III</b>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <b>217 West Washington St., Hagerstown, Maryland</b>			
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE <b>6/8/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Park Heights Cemetery</b>		23d. LOCATION (City or town), Co. (County) (State) <b>Brunswick, Md.</b>			
24. FUNERAL DIRECTOR <b>Peete Funeral Home</b>				ADDRESS <b>Brunswick, Md.</b>		25a. REC'D BY REG. STRAR DATE <b>JUN 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print)			First <b>Marshall</b>	Middle <b>Eugene</b>	Last <b>Monroe</b>		2a DATE KNOWN OF ESTI- DEATH MATED <input type="checkbox"/> Month Day Year <b>6 15 1968</b>		2b HOUR <b>5:30 PM</b>			
3 SEX <b>Male</b>	4 RACE <b>Negro</b>	5 DATE OF BIRTH <b>Nov. 2, 1940</b>	6 AGE (In years last birthday) <b>27 YRS</b>	IF UNDER 1 YEAR MONTHS <b>7</b> DAYS <b>13</b>		IF UNDER 24 HRS HOURS <b></b> MIN <b></b>		2c DATE PRONOUNCED DEAD Month <b>6</b> Day <b>15</b> Year <b>1968</b>		2d HOUR <b>8:15 AM</b>		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Washington</b>						
10. CITY OR TOWN OF DEATH <b>Near Sharpsburg</b>			11 NAME OF HOSPITAL OR INSTITUTION (If in hosp. tal give street address) <b>POTOMAC RIVER at Shepherdstown Bridge</b>			12a. USUAL OCCUPATION (Kind of work done during most of work ng life, even if retired) <b>Carpenter</b>		12b KIND OF BUSINESS OR INDUSTRY <b>Building</b>				
13a USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Washington</b>		13c CITY OR TOWN <b>Sharpsburg</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>227 W. Antietam St.</b>			
14. FATHER'S NAME First <b>Clarence</b>			Middle <b>H. Monroe</b>		Last <b></b>		15. MOTHER'S MAIDEN NAME First <b>Frances</b>			Middle <b>M.</b>		Last <b>King</b>
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b SOCIAL SECURITY NO (If yes give year or dates of service) <b>218-38-1606</b>		17 INFORMANT <b>227 W. Antietam St. Mr. Clarence H. Monroe Sharpsburg, Maryland</b>							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation Due to Drowning</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b></b> DUE TO, OR AS A CONSEQUENCE OF (c) <b></b>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0-5 Min</b>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>9-10-68</b>												
19a. DATE OF OPERATION <b>6-15-68</b>				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? <b></b>				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year <b>6-15-68</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Drowned while swimming in River</b>							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Potomac River</b>		21f LOCATION Street or R.F.D. No <b>River Near Shepherdstown</b>		City or Town <b>Wicoma</b>		County <b></b>		State <b>MD</b>		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>E. W. DITTO III</b>			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			22b DATE SIGNED <b>6-15-68</b>			
EXAMINER'S NAME (Type) <b>DR. E. W. DITTO III</b>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, c. ty, town, or county) <b>217 W. WASHINGTON ST., HAGERSTOWN, MD.</b>						
23a BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 18, 1968</b>		23c NAME OF CEMETERY OR CREMATORY <b>Tolson Chapel Cemetery</b>		23d LOCATION (City or Town) (County) (State) <b>Sharpsburg, Washington, Md.</b>						
24 FUNERAL DIRECTOR <b>Albert L. Leaf</b>			ADDRESS <b>Williamsport, Maryland.</b>			25a REC'D BY REGISTRAR <b>JUN 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

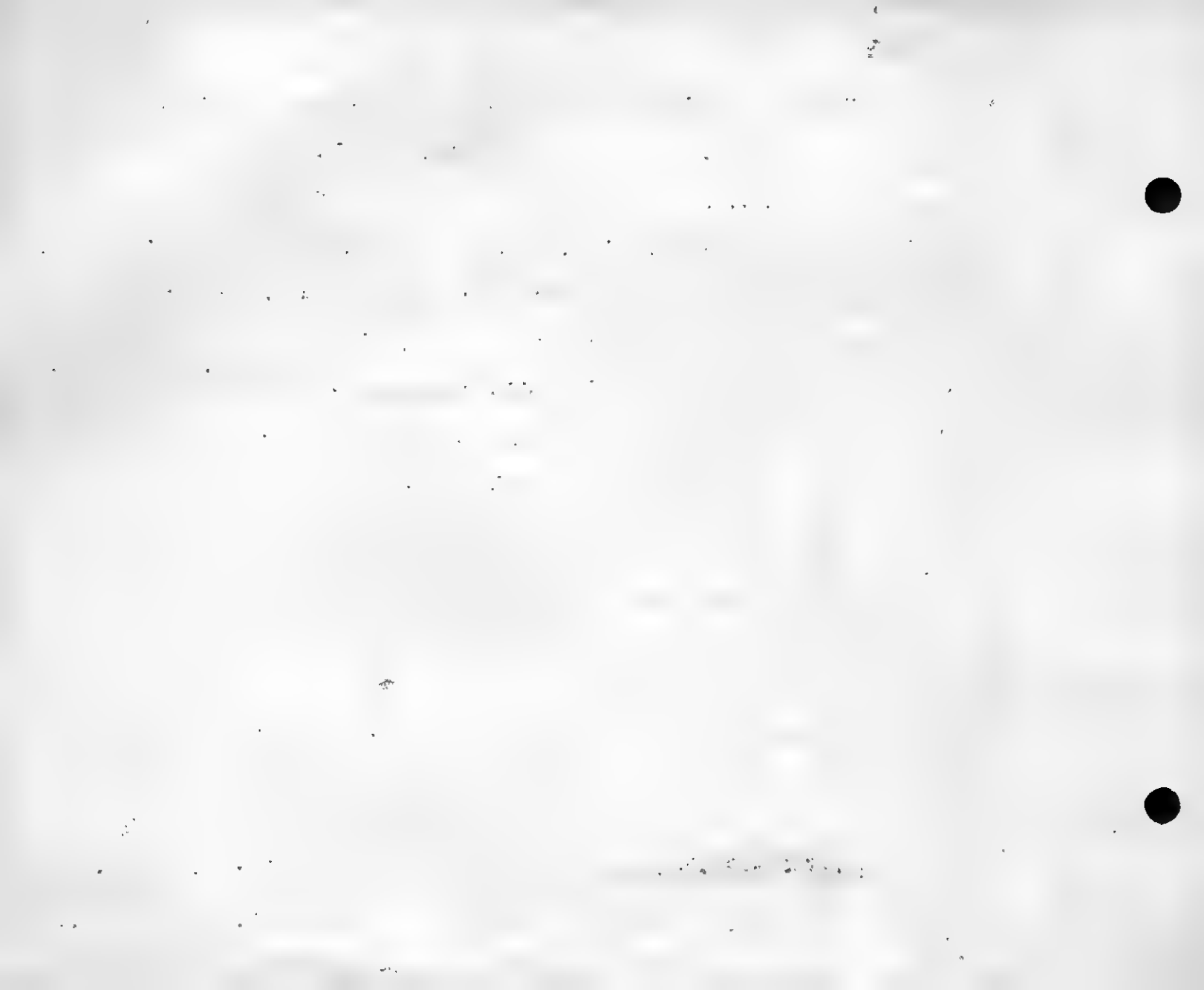
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 134  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

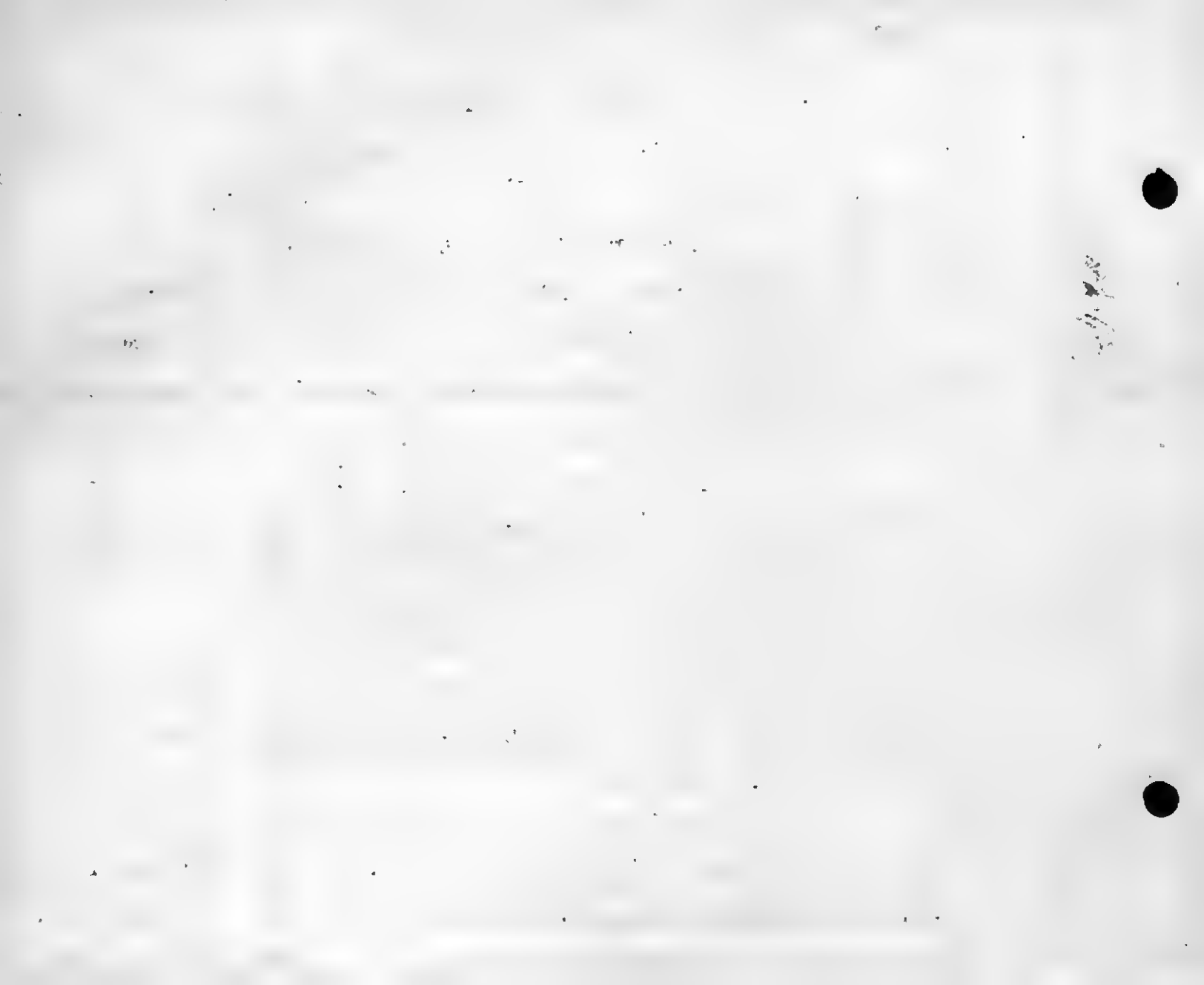
1. DECEASED NAME (Type or print) <b>GERALD EVAN MUNSON</b>			2a. DATE OF DEATH Month <b>17</b> Day <b>68</b> Year <b>1968</b>			2b. HOUR <b>1:10 PM</b>				
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>NOVEMBER 16, 1906</b>		6. AGE (In years last birthday) <b>61</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.				
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON COUNTY HOSP.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>POSTAL CLERK</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>US POST OFFICE</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>WASHINGTON</b>		13c. CITY OR TOWN <b>HAGERSTOWN</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>431 N. MULBERRY ST.</b>	
14. FATHER'S NAME First Middle Last <b>JOHN W MUNSON</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>NELLIE WELSH</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (a, or unknown) <input type="checkbox"/> NO <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO <b>214-09-1081</b>		17. INFORMANT <b>431 Address MULBERRY ST. HAGERSTOWN, MARYLAND</b> <b>MRS. BEATRICE MUNSON</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Renal failure, + subarachnoid hemorrhage</b> <b>4410</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Bacterial endocarditis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>2 months</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>11</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (I) <del>(we)</del> <b>(we)</b> attended the deceased from <b>June 6, 1968</b> , to <b>June 17, 1968</b> , that (I) <del>(we)</del> <b>(we)</b> lost saw the deceased alive on <b>June 9, 1968</b> , and that in (my) <del>(our)</del> <b>(our)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> <b>(we)</b> (did) <del>(did not)</del> view the body after death.										
22b. SIGNATURE <b>Richard E. Smith M.D.</b> DEGREE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>6/18/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>RICHARD E. Smith MD</b>					22e. ADDRESS <b>998 POTOMAC AVE., HAGERSTOWN, MD.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/20/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN, WASHINGTON CO., MD.</b>				
24. FUNERAL DIRECTOR <b>Charles M. Kagan</b> HAGERSTOWN, MARYLAND					25a. REC'D BY REGISTRAR <b>JUN 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove 'cardboard' pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
LEO			PAVLOV NAZARITI			JUNE 25 1968		7 A M		
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
MALE		WHITE		JUNE 5 1900		68 YRS.		IF UNDER 24 HRS. HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
RUSSIA		U.S.A.				WASHINGTON Md				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work no life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY				
HAGERSTOWN		WASHINGTON COUNTY HOSP.		PHOTOGRAPHER		PHOTO				
13a. U.S.A. RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
N.Y.		NEW YORK		NEW YORK				605 W 142ND STREET		
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last							
PAVLOV NAZARITI			MARIA (UNKNOWN)							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
NO			082-09-1727A		MRS ARTEMIS NAZARITI 605 W 142ND ST N.Y. NY					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ventricular fibrillation</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertension, infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>instantaneous</u> <u>5 wks</u> <u>8 yrs</u>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4201</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (the hospital) attended the deceased from <u>May 20, 1968</u> to <u>June 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 27, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Edson B Moody</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/25/68			
22d. PHYSICIAN'S NAME (Type) EDSON B MOODY M.D.					22e. ADDRESS 363 S. CLEVELAND AVE HAGERSTOWN MD.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
REMOVAL		6/26/68		JAREMA FUNERAL HOME		NEW YORK N.Y. N.Y.				
24. FUNERAL DIRECTOR <u>Charles Judge</u>					ADDRESS HAGERSTOWN MARYLAND		25a. REC'D BY REG STRAR DATE JUN 28 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 113-4  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last Paul Melvin Paden			2a. DATE OF DEATH Month Day Year June 30, 1968			2b. HOUR 7:15P <sup>M</sup>	
3. SEX Male		4. RACE White		5. DATE OF BIRTH Jan. 6, 1905		6. AGE (In years last birthday) 63 YRS.	
7a. BIRTHPLACE (State or foreign country) Hagerstown		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Inspector		12b. KIND OF BUSINESS OR INDUSTRY Metal Mfg.	
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last William Paden		15. MOTHER'S MAIDEN NAME First Middle Last Daisy Trovinger		16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) (If yes give war or dates of service) No			
16b. SOCIAL SECURITY NO. 214-09-6131		17. INFORMANT Address: Hagerstown, Md. Mrs. Mary L. Paden, 836 Guildford Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septicemia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Septicemia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 mos.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>April 1, 1968</u> , to <u>June 30, 1968</u> , that (I) (we) last saw the deceased alive and <u>June 30, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death							
22b. SIGNATURE <u>W.C. Brewer, Jr.</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 7/6/68	
22d. PHYSICIAN'S NAME (Type) W.C. Brewer, Jr.		22e. ADDRESS Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 7- 3- 68		23c. NAME OF CEMETERY OR CREMATORY Boonsboro Cemetery		23d. LOCATION (City or Town) (County) (State) Boonsboro, Wash. Co., Md.	
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.				25a. REC'D BY REGISTRAR PAUL - 9 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

FOR STATE HEALTH DEPT.

1 DECEASED-NAME (Type or Print)		First Anna		Middle Blanch		Last Panos		2a DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> 6 8 1968		2b HOUR 11:05 PM	
3 SEX female	4 RACE white	5 DATE OF BIRTH 4-5-1903	6 AGE (In years last birthday) 65 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month 6 Day 9 Year 1968		2d HOUR 6:30 PM	
7a BIRTHPLACE (State or foreign country) Virginia		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md					
10 CITY OR TOWN OF DEATH Hagerstown		11 NAME OF HOSPITAL, OR INSTITUTION (If not in hospital give street address) 518 Ridge St.				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Folder		12b KIND OF BUSINESS OR INDUSTRY Box Mfg.			
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Ohio		13b COUNTY Lucas		13c CITY OR TOWN Toledo		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER 1226 Sherman			
14. FATHER'S NAME First Middle Last Joseph Shifflett				15 MOTHER'S MAIDEN NAME First Middle Last Margaret Moore							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no		16b SOCIAL SECURITY NO. --		17. INFORMANT ADDRESS Mrs. Edward Moses, Toledo, Ohio							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY- IMMEDIATE CAUSE (a) Intoxication 17 Pounds 164/11/1 & combined 7309 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) effects of Librium & short action barbiturate DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Edward W. Ditto III</i> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED 6-9-68			
EXAMINER'S NAME (Type) DR. E. W. DITTO III				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify) Burial		23b DATE 6-12-68		23c NAME OF CEMETERY OR CREMATORY Forrest Cemetery		23d LOCATION (City or Town) (County) (State) Toledo, Ohio					
24 FUNERAL DIRECTOR Minnich Funeral Home Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUN 11 1968		25b REG. STRIP'S SIGNATURE <i>Charles Judge</i>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3, Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

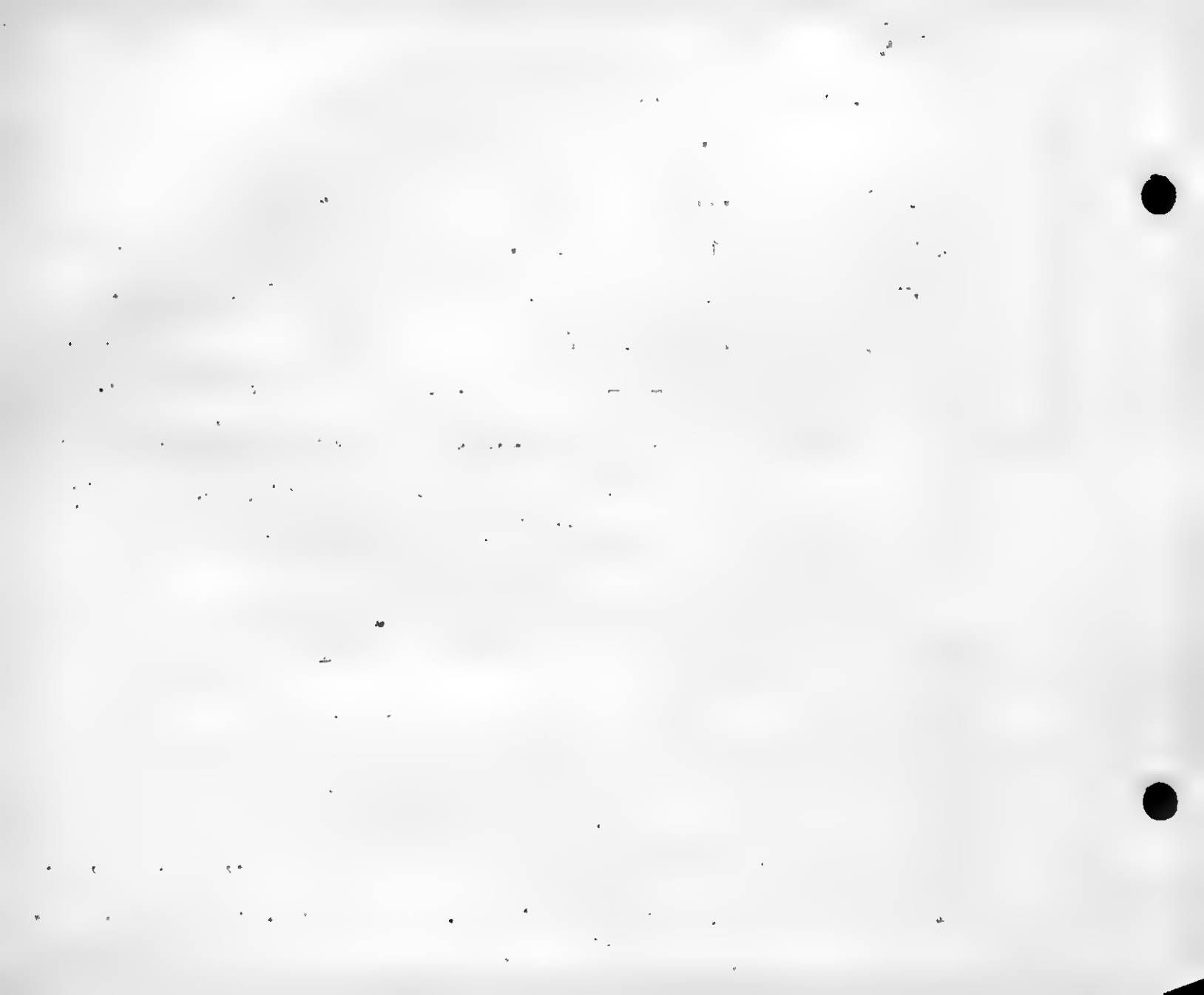
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled, in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

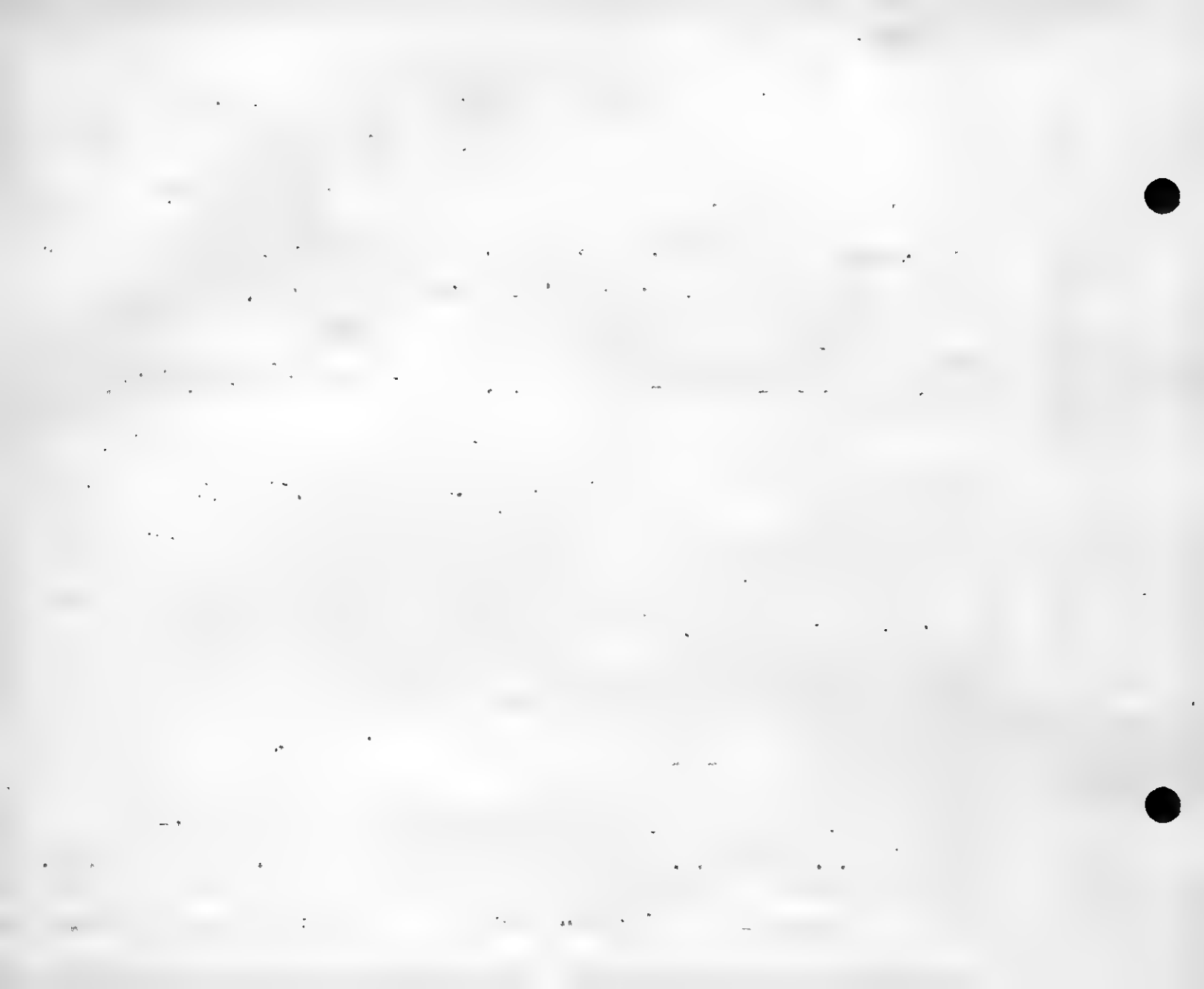
MARYLAND STATE DEPARTMENT OF HEALTH												
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or print) <b>ERIN</b> <sup>First</sup> <b>LOUISE</b> <sup>Middle</sup> <b>POPE</b> <sup>Last</sup>						2a. DATE OF DEATH <b>JUNE</b> Month <b>20</b> Day <b>1968</b>			2b. HOUR <b>M</b>			
3. SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>2/1/1913</b>		6 AGE (In years lost birthday) <b>55</b> YRS.		IF UNDER YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>MISSOURI</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>WASHINGTON</b>			Md			
10. CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>1230 SALEM AVE.</b>				12a USUAL OCCUPATION (Kind of work done during last week or last 12 months) <b>SCHOOL TEACHER</b>			12b KIND OF BUSINESS OR INDUSTRY <b>PUBLIC SCHOOL</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>				13b COUNTY <b>WASHINGTON</b>		13c CITY OR TOWN <b>HAGERSTOWN</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>1230 SALEM AVE.</b>		
14 FATHER'S NAME First Middle Last <b>HENRY F. McCULLOUGH</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>MARIE WILSON</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>NO</b>		(If yes give war or dates of service)		16b SOCIAL SECURITY NO <b>515-12-3912</b>		17 INFORMANT Address <b>MR. MERRITT POPE HAGERSTOWN MD.</b>						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))												
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Vascular accident probably, Myocardial infarct</u> minutes?												
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic heart disease</u> indefinite												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>and Hypertensive cardiovascular disease</u> "												
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <u>never</u> 19 <u>  </u> , to <u>  </u> 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>  </u> 19 <u>  </u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. <u>Seen in absence of Dr. Bayer</u>												
22b. SIGNATURE <u>Robert F. Keadle</u>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>6-21-68</u>						
22d. PHYSICIAN'S NAME (Type) <b>Robert F. Keadle</b>		22e. ADDRESS <b>580 Northern Ave., Hagerstown, Md.</b>										
23a. BURIAL, CREMATION, REMAINS (Specify)		23b. DATE <b>6/24/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>REST HAVEN CEM.</b>		23d. LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>						
24. FUNERAL DIRECTOR <u>W. J. ...</u>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 25 1968</b>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>						



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARTLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)		First <b>ETHEL</b>		Middle <b>LENOR</b>		Last <b>PRESTON</b>		2a. DATE OF DEATH Month <b>June</b> Day <b>20</b> Year <b>1968</b>		2b HOUR M
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>Oct. 15 1900</b>		6 AGE (In years last birthday) <b>67</b> YRS		IF UNDER 1 YEAR MONTHS <b>8</b> DAYS <b>4</b>		IF UNDER 24 HRS. HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>		MD		
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>29 E. Salisbury St.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>				
13a. USUA. RES. DENCE (Where deceased admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Williamsport</b>		13d. ASIDE CITY LIMITS? <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>29 E. Salisbury St.</b>		
14 FATHER'S NAME First <b>Charles</b> Middle <b>Bramble</b> Last <b>Bramble</b>		15 MOTHER'S MAIDEN NAME First <b>Nellie</b> Middle <b>Long</b> Last <b>Long</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b>		(If yes give year or dates of service) -----		16b SOCIAL SECURITY NO <b>216-07-1209</b>		17. INFORMANT <b>Mr. Isaac Preston</b>		29 E. Address <b>Williamsport Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac arrest</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Multiple cardiac arrhythmia</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Long term Hypertensive disease</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>&lt; 5 mins</b> <b>2 yrs</b> <b>50 yrs</b>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>none</b>										
19a. DATE OF OPERATION <b>6-12-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>endometrial Sarcoma</b>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>March</b> , 19 <b>59</b> , to <b>6-20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6-18-</b> <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>M.E. Byrkit</b>		22c. DATE SIGNED <b>6-20-68</b>		22d. PHYSICIAN'S NAME (Type) <b>M.E. Byrkit M.D.</b>						
22e. ADDRESS <b>20 West Potomac St. Williamsport, Md.</b>										
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 22-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Williamsport Washington Md</b>				
24. FUNERAL DIRECTOR <b>Jennie E. Leaf Williamsport Maryland</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



## CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) John Arthur Randall			2a. DATE OF DEATH June 9, 1968		2b. HOUR 9:30A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH July 25, 1881		6. AGE (In years last birthday) 88 YRS.	IF UNDER 1 YEAR MONTHS DAYS 10 14
7a. BIRTHPLACE (State or foreign country) Durham, Maine	7b. CITIZEN OF WHAT COUNTRY? U. S. A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Boonsboro	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fainney-Keedy Mem. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Educator		12b. KIND OF BUSINESS OR INDUSTRY Education
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Keedysville	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER Rfd. 1	
14. FATHER'S NAME First Middle Last Greenfield A. Randall		15. MOTHER'S MAIDEN NAME First Middle Last Julia Penley			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give year or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Georgiana Randall, Rfd. 2, Boonsboro, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiac Warden Disease</u> 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs 1 wk					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, nat'l medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from March 10, 1968, to June 9, 1968, that (I) (we) last saw the deceased alive on June 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE G. W. Levan M.D.		22c. DATE SIGNED 6/10/68		22d. PHYSICIAN'S NAME (Type) G. W. Levan M.D.	
22e. ADDRESS Boonsboro, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation		23b. DATE 6-11-68		23c. NAME OF CEMETERY OR CREMATORY Fort Lincoln Crematory	
23d. LOCATION (City or Town) (County) (State) 3201 Bladensburg Rd. Wash. D.C.					
24. FUNERAL DIRECTOR John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.		25a. REC'D BY REGISTRAR JUN 12 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1 DECEASED-NAME (Type or Print)			First <b>DENNIS</b>		Middle <b>EUGENE</b>		Last <b>REESER</b>		2a DATE KNOWN OF DEATH Month <input type="checkbox"/> Day <input checked="" type="checkbox"/> Year <input type="checkbox"/> <b>6-9 1968</b>			2b HOUR <b>1:45 PM</b>
3 SEX <b>Male</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>April 30-51</b>		6 AGE (in years) <b>17</b> YRS	7 UNDER 24 HRS MONTHS <b>1</b> DAYS <b>9</b>		8 IF UNDER 24 HRS MAN		2c DATE PRONOUNCED DEAD Month <b>6</b> Day <b>9</b> Year <b>1968</b>		2d HOUR <b>4:20 PM</b>	
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Washington</b>						
10. CITY OR TOWN OF DEATH <b>Near Charloten, Md.</b>			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Potomac River</b>			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>			12b KIND OF BUSINESS OR INDUSTRY <b>Brick Yard</b>			
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>			13b COUNTY <b>Washington</b>			13c CITY OR TOWN <b>Pinesburg Williamsport</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>Williamsport, Md. RFD #2</b>		
14 FATHER'S NAME First <b>Briscoe</b> Middle <b>Reesor</b> Last <b>Reesor</b>			15 MOTHER'S MAIDEN NAME First <b>Dorothy</b> Middle <b>Ambrose</b> Last <b>Ambrose</b>			16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>			16b SOCIAL SECURITY NO <b>214-54-0237</b>		17 INFORMANT <b>Mr. Briscoe G. Reesor</b>	
16a ADDRESS <b>Pinesburg Williamsport Md RFD #2</b>												
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Asphyxiation Due to Drowning</b>												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year <b>1:40 PM 6-9 1968</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Drowned in Potomac River</b>				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Potomac River</b>				21f. LOCATION Street or RFD No City or Town County State <b>Nr. Charleston Washington Md</b>				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , inspection <input type="checkbox"/> , inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Edward W. Ditte III</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <b>6-9-68</b>				
EXAMINER'S NAME (Type) <b>Edward W. Ditte III</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				ADDRESS (Street, city, town, or county) <b>Hagerstown, Md. Wash.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>June 12-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Greenlawn Cemetery</b>			23d. LOCATION (City or Town) (County) (State) <b>Williamsport Md.</b>				
24. FUNERAL DIRECTOR <b>Albert L. Leaf Williamsport Md.</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 11 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		





FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1 DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR
RICHARD LEWIS REPP						DATE KNOWN OF DEATH MATED <input checked="" type="checkbox"/> 6 10 1968			7:20 PM
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR		7 LATER 24 HRS		2c. DATE PRONOUNCED DEAD	
MALE	WHITE	AUG. 6, 1939	28 YRS	MONTHS DAYS		HOURS MIN		Month JUNE Day 10 Year 1968	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9 COUNTY OF DEATH			
MARYLAND		U.S.A.				WASHINGTON, Md			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
RURAL HAGERSTOWN			-----			BRICK MASON			HOME BLDG.
13a. USUAL RESIDENCE (Where deceased lived, if institution Res. dence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY (L.M. 15?)	13e. STREET AND NUMBER
MARYLAND			WASHINGTON			HAGERSTOWN		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	SHARPSBURG PIKE
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
RICHARD CLAYTON REPP			MARGARET SPRECHER						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17 INFORMANT			
NO			212-38-9501			RT #2 ADDRESS			
						MR. RICHARD C. REPP HAGERSTOWN, MARYLAND			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)									
955X DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.									
(b) DUE TO, OR AS A CONSEQUENCE OF									Turned
(c) DUE TO, OR AS A CONSEQUENCE OF									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
7011V									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2 Item 18)				
			7:20 6-10-1968		Self inflicted gunshot wound				
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County	State
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		Home		Rt #3		Hagerstown		Wash	Md
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			E.W. DITTO, 3rd. M.D.			JUNE 11, 1968			
			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			217 W. WASH ST. HAGERSTOWN, MD.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
BURIAL			6/12/68		CEDAR LAWN MEMORIAL PARK		WASHINGTON COUNTY, MARYLAND		
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		
Charles M. Rousen					HAGERSTOWN, MARYLAND		DATE JUN 14 1968		
							25b. REGISTRAR'S SIGNATURE		
							Charles J. Jager		

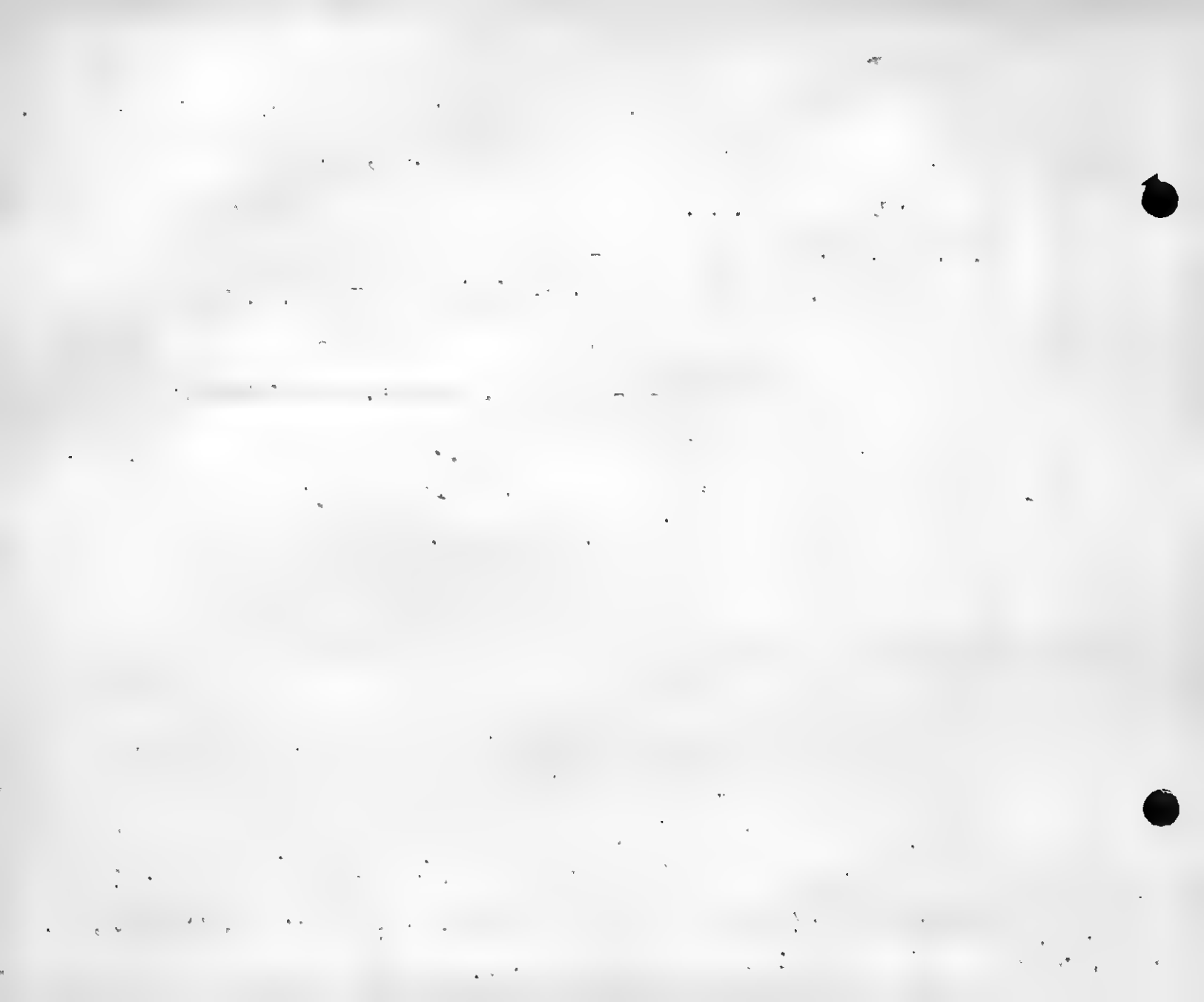


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>David M. Ridenour</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>15</b> Year <b>1968</b>			2b. HOUR <b>8 a.m.</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Sept. 25, 1878</b>		6. AGE (In years last birthday) <b>89</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.	
10. CITY OR TOWN OF DEATH <b>R. D. 3, Smithsburg</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>- - -</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Farm</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Smithsburg</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <b>R. D. 3</b>		14. FATHER'S NAME First <b>Levi</b> Middle <b>Ridenour</b> Last <b>Ridenour</b>		15. MOTHER'S MAIDEN NAME First <b>Malinda</b> Middle <b>Stephy</b> Last <b>Stephy</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, (no, or unknown) <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <b>215-366947A</b>		17. INFORMANT Address <b>Mrs. George M. Rowe Smithsburg #3, Maryland</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4121 cerebral thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>hypertensive cardiac sclerosis</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>1 day</b> <b>2 c</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>T.D.M.</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>June 13, 1968</b> to <b>June 15, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 15, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>Geo. G. H. Kohler M.D.</b>				22c. DATE SIGNED <b>June 17, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Geo. G. H. Kohler</b>				22e. ADDRESS <b>Smithsburg, Washington, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Entombment</b>		23b. DATE <b>6/18/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Smithsburg Mausoleum</b>		23d. LOCATION (City or Town) (County) (State) <b>Smithsburg, Washington, Md.</b>	
24. FUNERAL DIRECTOR <b>Walter G. Shae</b>				25a. REC'D BY REGISTRAR <b>WAT</b>		25b. REGISTRAR'S SIGNATURE <b>June 19, 1968</b>	

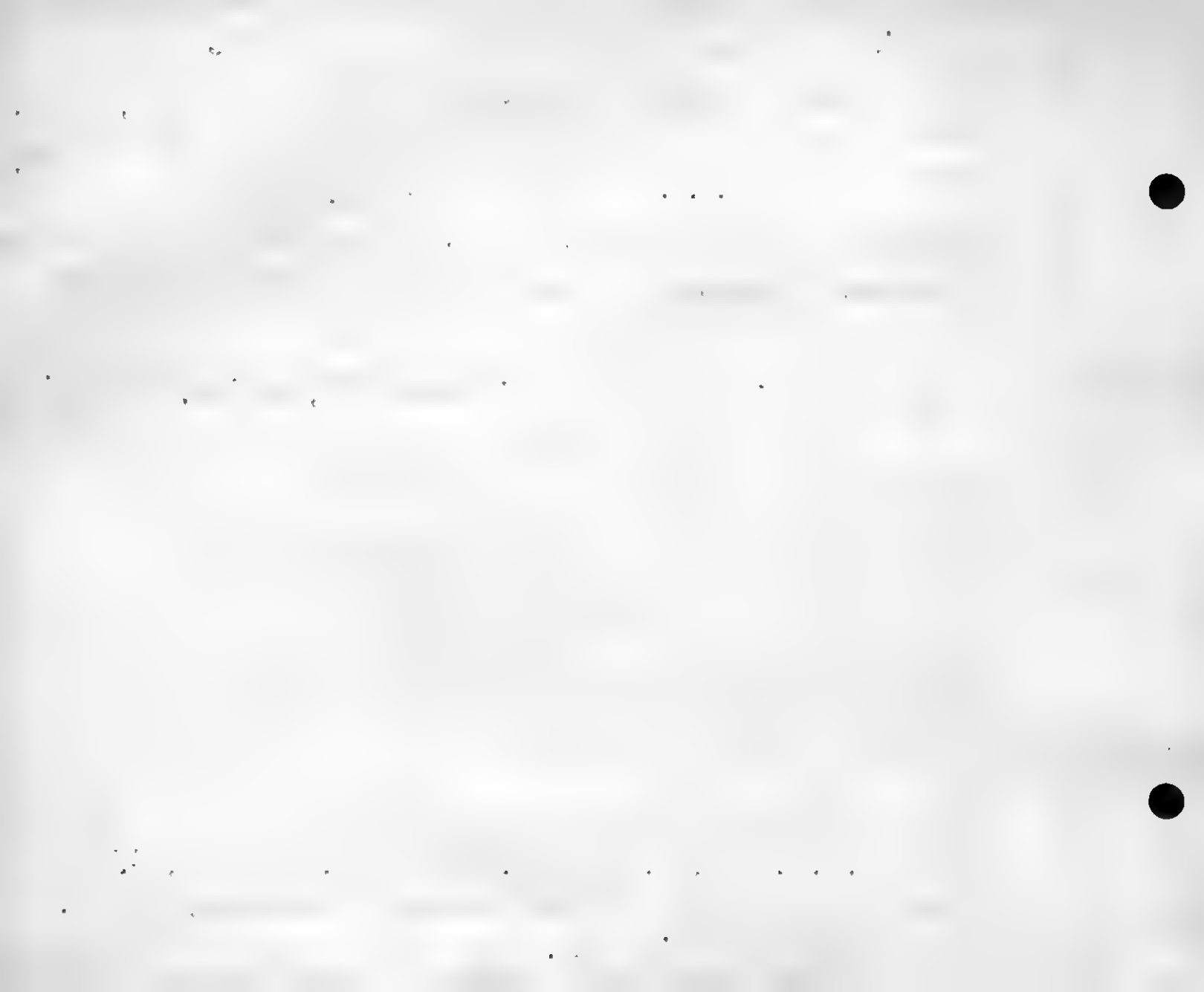


FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-101. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Five pages (and 2 with the State Department of Health) prior to burial, cremation, or removal, and in any event within 72 hours after death.

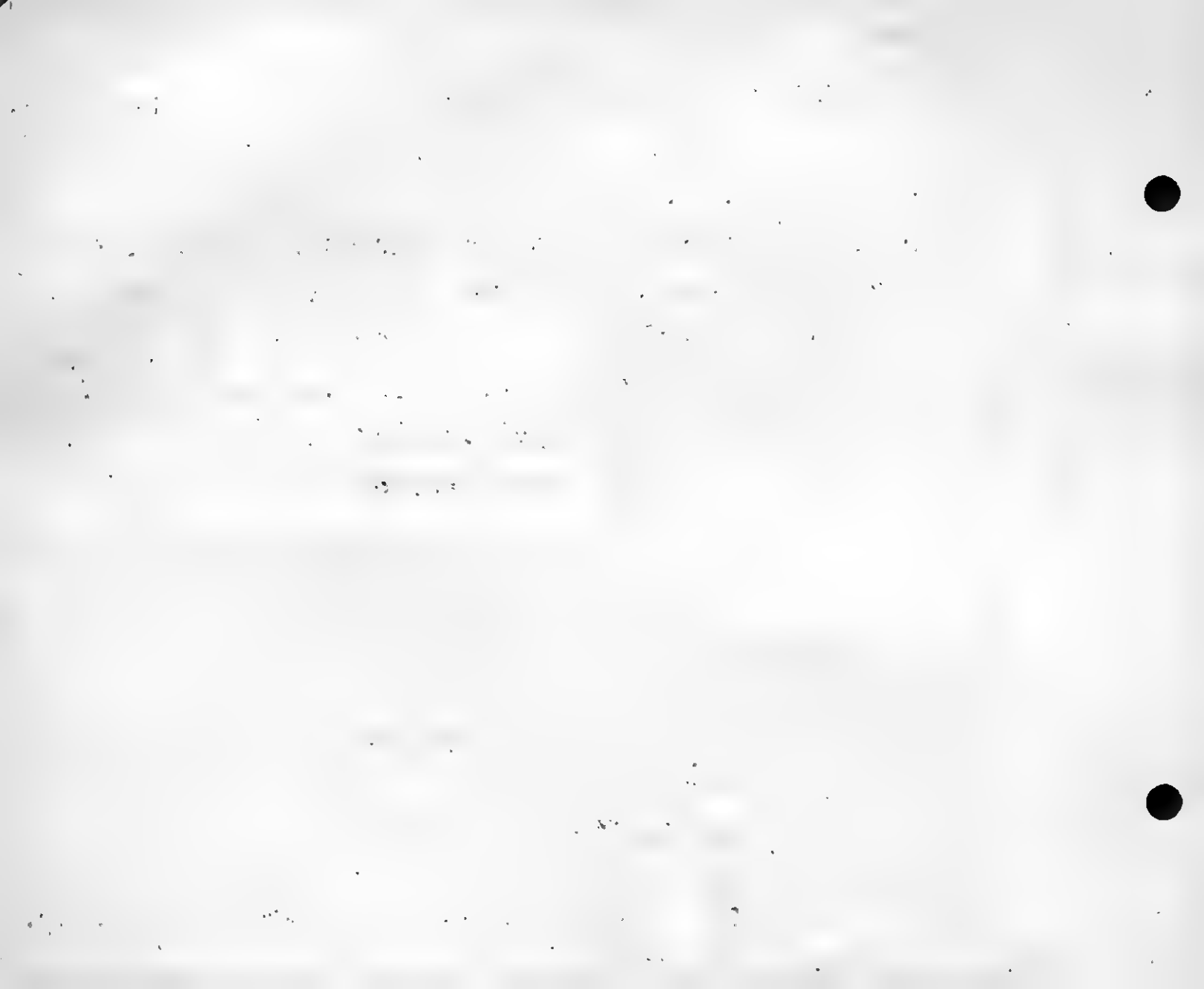
Items 18, 22a film 401 6/22 7-1-68 mt Item 586, Film 401 6/22										DIVISION OF VITAL RECORDS, 401 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH																													
1 DECEASED NAME (Type or Print) First Middle Last <b>Lloyd Douglas Sales</b>										2a DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year <input checked="" type="checkbox"/> <b>June 14, 1968</b> 2b HOUR <b>3 A.M.</b>																													
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>February 7, 1921</b>		6 AGE (In years last birthday) <b>47</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c DATE PRONOUNCED DEAD Month <b>June</b> Day <b>14</b> , Year <b>1968</b> 2d HOUR <b>9:20 A.M.</b>																											
7a BIRTHPLACE (State or foreign country)				7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. COUNTY OF DEATH <b>Washington, Md</b>																											
10 CITY OR TOWN OF DEATH <b>Hagerstown</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>820 Concord St.</b>								12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Attendant</b>				12b KIND OF BUSINESS OR INDUSTRY <b>Gas Station</b>																							
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>				13b COUNTY <b>Washington</b>				13c CITY OR TOWN <b>Hagerstown</b>				13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e STREET AND NUMBER <b>820 Concord Street</b>																							
14 FATHER'S NAME First Middle Last										15 MOTHER'S MAIDEN NAME First Middle Last																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>										16b. SOCIAL SECURITY NO. <b>N.W.2 230-09-7239</b>										17. INFORMANT ADDRESS <b>Mrs. Orphia Ebersole 820 Concord St. Hagerstown, Maryland.</b>																			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pending/</b> <b>Acute Alcoholism with</b> <b>3009</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>probable Aspiration of Vomitus</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Few minutes</b>																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>322</b>																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>										21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)																			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										21f LOCATION Street or R.F.D. No City or Town County State																			
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>																																							
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b> M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										22b. DATE SIGNED <b>June 17, 1968</b>																			
EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>										ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>																			
ADDRESS (Street, city, town, or county) <b>215 W. Washington St., Hagerstown, Md.</b>																																							
23a BURIAL, CREMATION (Type) <b>Burial</b>										23b DATE <b>June 17/68</b>										23c NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>										23d LOCATION (City or Town) (County) (State) <b>Hagerstown, Maryland.</b>									
24 FUNERAL DIRECTOR <b>Hagerstown, Md. Andrew Coffman Funeral Home Inc.</b>										ADDRESS										25a. REC'D BY REGISTRAR <b>JUN 20 1968</b>										25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>									



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First WILLIAM		Middle JOHN		Last SCHEELEY		2a. DATE OF DEATH Month 5 Day 1968		2b. HOUR 1 P.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH 1/13/1886		6. AGE (In years last birthday) 82 YRS.		7. UNDER 1 YEAR MONTHS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign) PENNSYLVANIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON MD.					
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, then address) FAHRNEY KEEDY MEN. HOME		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) RETIRED ENGINEER		12b. KIND OF BUSINESS OR INDUSTRY RAIL ROAD					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN SAN MAR		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER RURAL BOONSBORO			
14. FATHER'S NAME First MATHew		Middle		Last SCHEELEY		15. MOTHER'S MA DEN NAME First CATHERINE		Middle		Last KILGUS	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. (If yes give war or dates of service) 707-16-796		17. INFORMANT MR. WILLIAM L. SCHEELEY		Address HAGERSTOWN MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardio vascular</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4127</u> (b) <u>Acute pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>10 yrs</u> <u>1 wk</u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 10, 1968</u> , to <u>June 5, 1968</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>June 5, 1968</u> , and that in (my) ( <del>our</del> ) opinion death occurred on the date and hour and from the causes stated above, (I) ( <del>was</del> ) ( <del>did</del> ) ( <del>did not</del> ) view the body after death.											
22b. SIGNATURE <u>G. W. LeVan M.D.</u>		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <u>6/7/68</u>					
22d. PHYSICIAN'S NAME (Type) <u>G. W. LeVan M.D.</u>		22e. ADDRESS <u>Boonsboro, Md</u>									
23a. BURIAL, CREMATION, or other disposition <u>BURIED</u>		23b. DATE <u>6/8/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>REST HAVEN CEM.</u>		23d. LOCATION (City or Town) <u>HAGERSTOWN WASH.</u>		(County)		(State) <u>MD.</u>	
24. FUNERAL DIRECTOR <u>W. T. Vincent, Hagerstown, Md.</u>		ADDRESS		25a. RECD. BY REGISTRAR <u>JUN 12 1968</u>		25b. REGISTERED BY <u>John J. Judge</u>					





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3/Paper 5 may be retained for your files.

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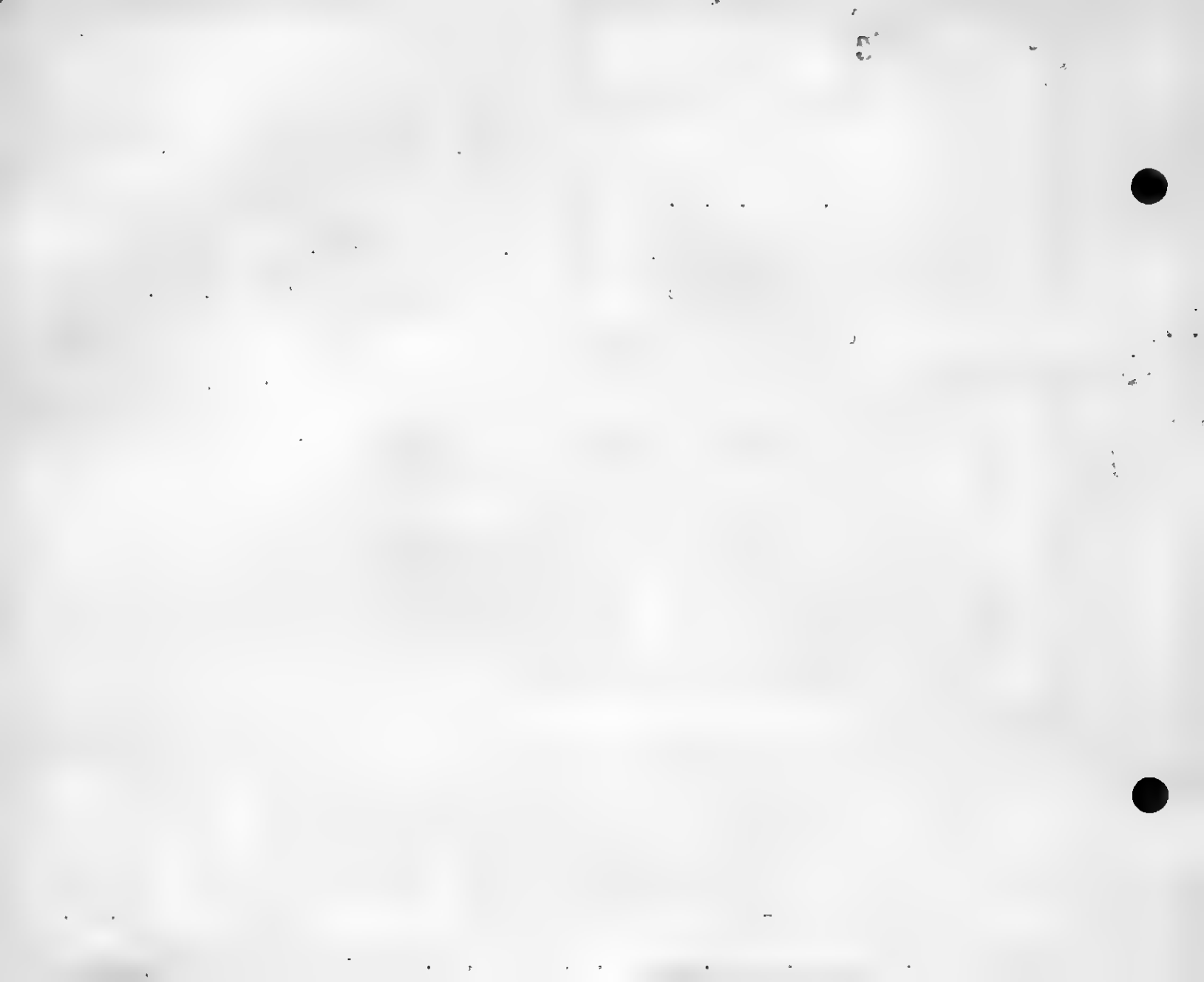
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)		First <b>WILLIAM</b>		Middle <b>EDWARD</b>		Last <b>SHAFFER</b>		2a DATE KNOWN OF ESTI DEATH MATED <input type="checkbox"/> Month Day Year <b>JUNE 23 68</b>		2b HOUR a M	
3 SEX <b>MALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>9/6/1901</b>		6 AGE (In years last birthday) <b>66</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>WASHINGTON</b>		2c DATE PRONOUNCED DEAD Month Day Year <b>JUNE 23 68</b>		2d HOUR M	
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WASHINGTON COUNTY HOSPITAL</b>				12a USUAL OCCUPATION (If retired, state date when most of work was discontinued) <b>RETIRED PLUMBER</b>		12b KIND OF BUSINESS OR INDUSTRY <b>CONTRACT</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) <b>MARYLAND</b>				13b COUNTY <b>WASHINGTON</b>		13c CITY OR TOWN <b>HAGERSTOWN</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <b>225 S. POTOMAC ST.</b>	
14 FATHER'S NAME First Middle Last <b>WILLIAM HENRY H. SHAFFER</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>PHIANNA RHODES</b>				16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			
16b SOCIAL SECURITY NO <b>214-09-2198A</b>				17 INFORMANT <b>MR. GEARID ALEXANDER</b>				ADDRESS <b>HAGERSTOWN MD.</b>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Congestive failure</b> DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) <b>yrs.</b> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (m) <b>Tbc.-active., Fracture of right hip., Chronic alcoholism.</b>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month Day Year HOUR A M <b>6/10/68</b> P M <b>9:30</b>				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fall on Baltimore Street</b>			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street factory, office by dining, etc.) <b>Baltimore St.</b>				21f LOCATION Street or R.F.D. No City or Town County State <b>Baltimore St. Hagerstown Wash. Md.</b>			
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <b>Howard N. Weeks</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASS STANT MEDICAL EXAMINER <input type="checkbox"/> 22b DATE SIGNED <b>6/24/68</b>				EXAMINER'S NAME (Type) <b>Howard N. Weeks, M. D.</b> MD <b>580 Northern Avenue, Hagerstown, Md.</b> ADDRESS (Street, city, town, or county)			
23a BURIAL CREMATION REMOVED <b>BURIAL</b>				23b DATE <b>6/25/68</b>				23c NAME OF CEMETERY OR CREMATORY <b>ROSE HILL CEM.</b>			
24 FUNERAL DIRECTOR <b>W. J. Norment, Hagerstown, Md.</b>				23d LOCATION (City or Town) (County) (State) <b>HAGERSTOWN WASH. MD.</b>				25a REC'D BY REG STRAR DATE <b>JUN 26 1968</b>			
				25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH		
Henry			Jacob		Show		June		Month 29 Day 1968 Year 3:00P M		
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		7. IF UNDER 1 YEAR		
Male		White		Nov. 2, 1881			66 YRS.		MONTHS 7 DAYS 27 HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Fairplay, Md.			U. S. A.					Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Boonsboro			Fahrney- Keedy Mem. Home			Stock Clerk					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Frederick			Frederick				522 Trail Ave.	
14. FATHER'S NAME			First		Middle		Last		15. MOTHER'S MAIDEN NAME		
Jacob			Show						Eveline Hieghberger		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT Address					
No.			217-10-9763			Fahrney- Keedy Home Records, Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Aplastic anemia</u>										5 yrs	
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Pneumonia</u>										2 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>										20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)										21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>										21f. LOCATION Street or R.F.D. No. City or Town County State	
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)											
22a. I certify that (I) (this hospital) attended the deceased from Sept 10, 1967, to June 29, 1968, that (I) (we) last saw the deceased alive on June 29, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>G. W. LeVan</u>										22c. DATE SIGNED July 1, 1968	
22d. PHYSICIAN'S NAME (Type) <u>G. W. LeVan</u>										22e. ADDRESS <u>Boonsboro, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial			7-2-68		Fairview Cemetery			Keedysville, Wash. Co., Md.			
24. FUNERAL DIRECTOR						ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.								JUL - 5 1968		Charles Judge	

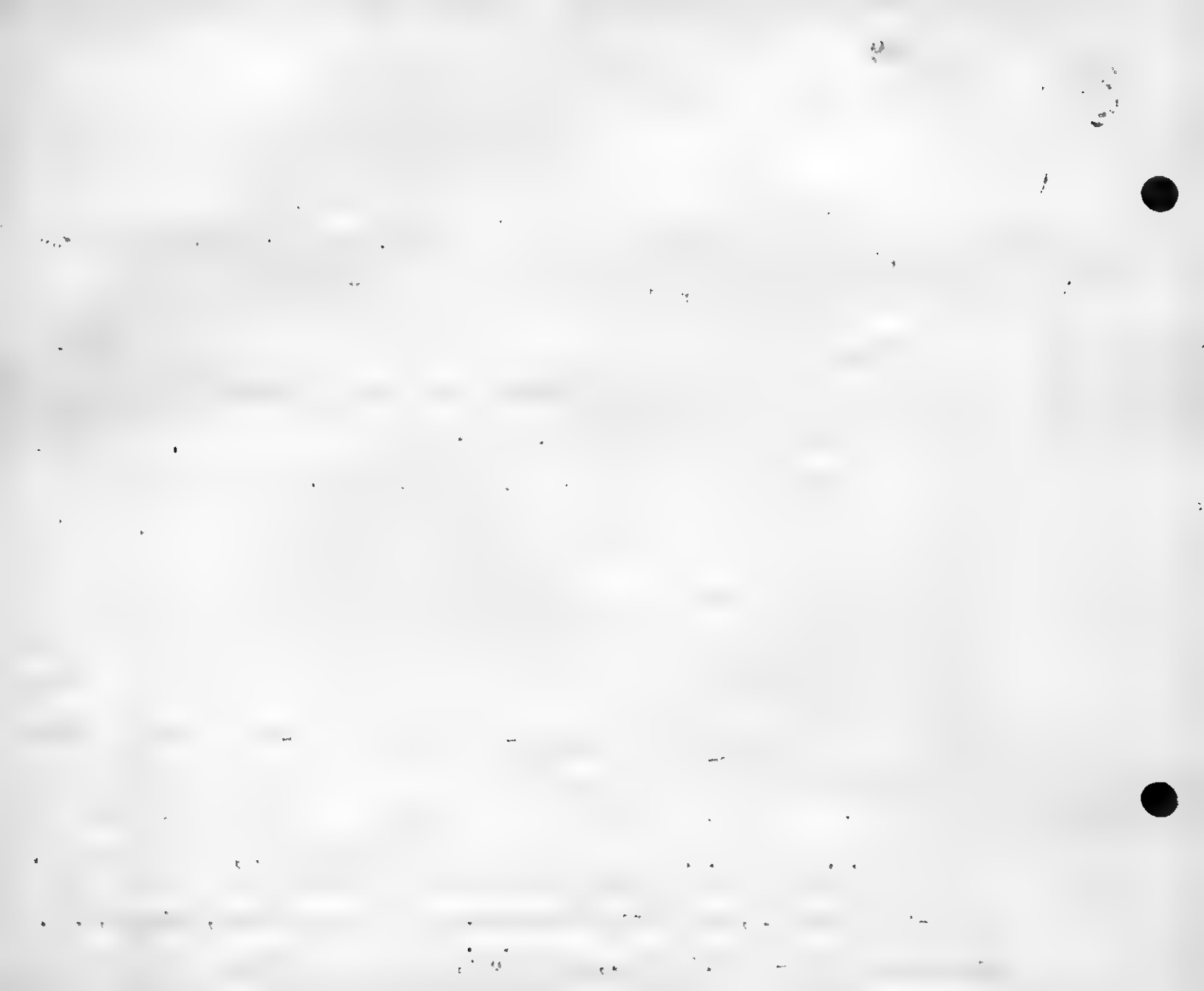


MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <i>Philip</i>			First Middle Last		2a. DATE OF DEATH Month <i>June</i> Day <i>25</i> Year <i>1968</i>			2b. HOUR <i>6:30 P.M.</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Jan 9, 1887</i>		6. AGE (In years last birthday) <i>81</i> YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS M.N.	
7a. BIRTHPLACE (State or foreign country) <i>Martinsburg W.Va.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>American</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i>		Md.	
10. CITY OR TOWN OF DEATH <i>Williamsport</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Williamsport Sanitarium</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Machinist &amp; tool maker</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Navy Yard</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>West Va.</i>		13b. COUNTY <i>Berkeley</i>		13c. CITY OR TOWN <i>Hedgesville</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>R. 7. D #3</i>	
14. FATHER'S NAME <i>George T</i>			First Middle Last		15. MOTHER'S MAIDEN NAME <i>Nancy</i>			First Middle Last <i>Albertus</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i>		16b. SOCIAL SECURITY NO. <i>No</i>		17. INFORMANT <i>Mrs. Florence Showers - Hedgesville, West Va.</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Pneumonia</i> <i>4x70</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Congestive heart failure</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4 days</i> 4 days 4 days								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i> <i>4 days</i>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4x70</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>5-7-68</i> , 19 <i>68</i> , to <i>6-24</i> , 19 <i>68</i> , that (I) <i>and</i> saw the deceased alive on <i>6-24</i> , 19 <i>68</i> , and that in (my) <i>our</i> opinion death occurred on the date and hour and from the causes stated above, (I) <i>and</i> (did not) view the body after death.									
22b. SIGNATURE <i>M.E. Byrkit M.D.</i>				DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>6-27-68</i>			
22d. PHYSICIAN'S NAME (Type) <i>M.E. Byrkit M.D.</i>				22e. ADDRESS <i>28 West Potomac St., Williamsport Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>June 27, 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Hill Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Martinsburg, Berkeley, W. Va.</i>			
24. FUNERAL DIRECTOR <i>Howard R. Brown</i>		ADDRESS <i>W. Va.</i>		25a. REC'D BY REGISTRAR <i>Brown Funeral Home-327 W. King St., Martinsburg,</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		DATE <i>JUL - 1 1968</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

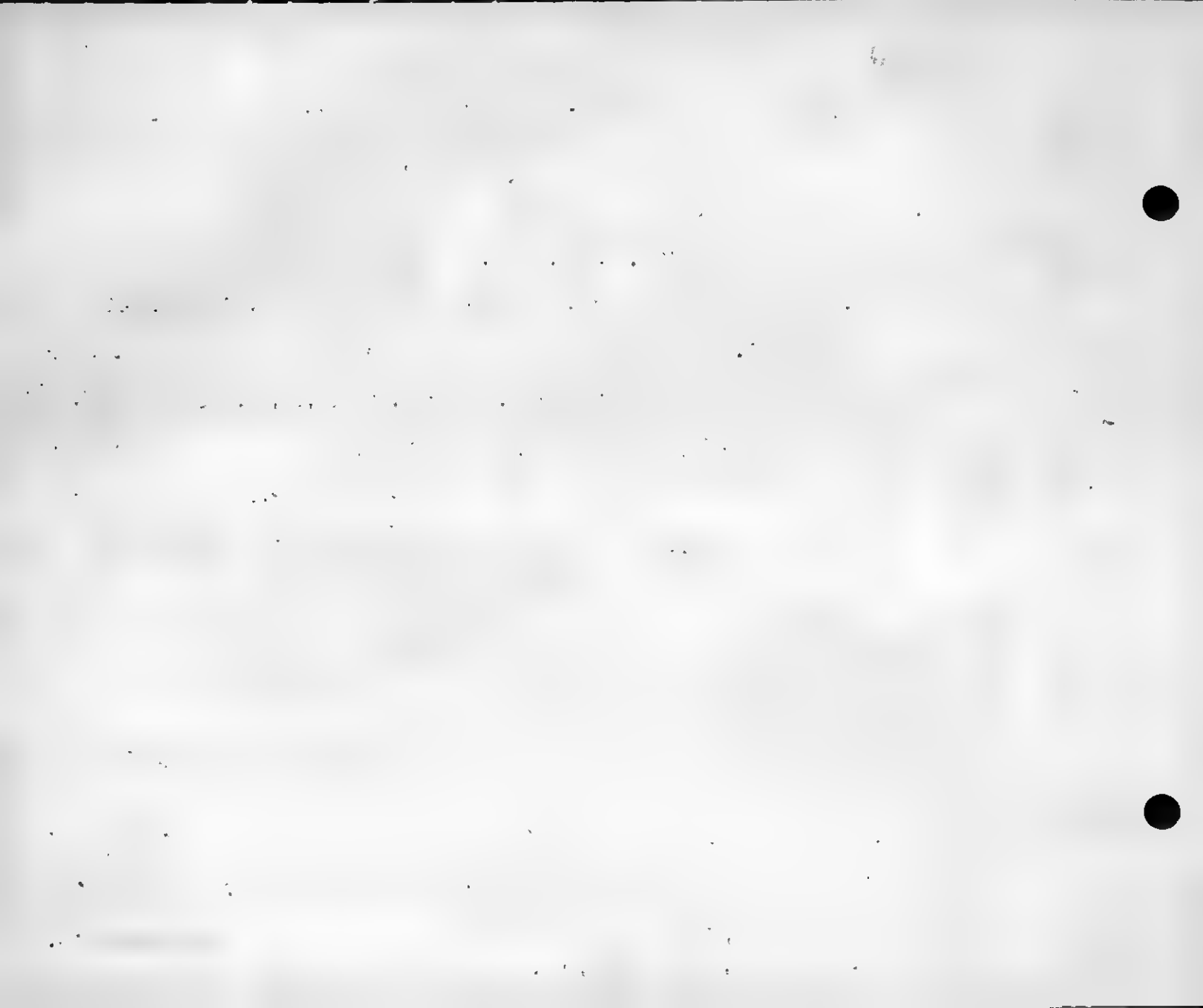
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Charles Hamilton Slick</b>			2a. DATE OF DEATH June 15 Day 1968			2b. HOUR M			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>April 14, 1889</b>		6. AGE (In years last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Md.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Smithsburg</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>47 N. Main Street</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Shop</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Smithsburg</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>47 N. Main Street</b>	
14. FATHER'S NAME First Middle Last <b>William T. Slick</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Annie - Masters</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>214-03-5704</b>		17. INFORMANT <b>Mrs. Susan M. Slick</b>		Address <b>24, N. Main St. Smithsburg, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Myocardial infarction</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerosis - 99 percent</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>722</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b> <b>4 yrs</b> <b>1 day</b>	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5/20</b> , 19 <b>68</b> , to <b>6/15</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>6/15</b> , 19 <b>68</b> , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Geo. A. Koller M.D.</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>6/17/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Geo. A. Koller M.D.</b>		22e. ADDRESS <b>Smithsburg, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>June 18, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Cavetown Cemetery</b>		23d. LOCATION (City or town) (County) (State) <b>Cavetown Washington Md.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Smithsburg, Md.</b>				25a. REC'D BY REGISTRAR <b>JUN 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. ...</b>			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 15-1-64  
304 REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>Margaret Ruth Smith</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>18</b> Year <b>1968</b>			2b. HOUR <b>8:25 P.M.</b>			
3. SEX <b>female</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>Nov. 23, 1896</b>		6. AGE (In years lost birthday) <b>71</b> YRS.		IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Wash. Co. Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>clerk</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Dept. store</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>21 Berner Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Franklin D. Miner</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Sarah E. Weaver</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address <b>John W. Smith, Hagerstown, Md.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage, multiple</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last (b) <b>Hypertensive cardiovascular disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>XXXXXXXXXXXXXXXXXXXX</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 weeks</b>  <b>Unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Diabetes mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <b>YES</b> <input type="checkbox"/> <b>NO</b> <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>5-10-68</b> , 19____, to <b>6-16-68</b> , 19____, that (I) <b>(X)</b> last saw the deceased alive on <b>6-16-68</b> , 19____, and that in (my) <b>(X)</b> opinion death occurred on the date and hour and from the causes stated above, (I) <b>(X)</b> <b>(did not)</b> view the body after death									
22b. SIGNATURE <b>E. R. Lardizabal</b>				DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>June 18, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>E. R. Lardizabal, M. D.</b>				22e. ADDRESS <b>300 N. Potomac St. Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6-19-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. View Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Ringgold, Md.</b>			
24. FUNERAL DIRECTOR <b>Minnich Funeral Home, Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 20 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or print) First Middle Last <b>Lloyd Amos Sponseller</b>			2a. DATE OF DEATH Month Day Year <b>June 22 1968</b>		2b. HOUR M <b></b>
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>November 20, 1890</b>		6. AGE (in years last birthday) <b>77</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS <b></b>
7a. BIRTHPLACE (State or foreign country) <b>Adams Co. Penna.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of work or life, even if retired.) <b>Cabinet Maker</b>	
12b. KIND OF BUSINESS OR INDUSTRY <b>Furniture</b>					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admision) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>	13c. CITY OR TOWN <b>Beaver Creek</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>R # 1 Hagerstown</b>
14. FATHER'S NAME First Middle Last <b>Rufus Samuel Sponseller</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mandilla Maria Snyder</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>214-09-6871</b>	17. INFORMANT <b>Mrs. L.A. Sponseller R # 1 Hagerstown, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction due to Coronary</b> <b>4100</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerosis + Advanced Bilateral</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Nephrosclerosis</b> Approximate Interval Between Onset and Death <b>72 hrs</b> <b>5-10 yrs</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Prostate hypertrophy, Benign Diverticulosis sigmoid colon</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>June 20, 1968</b> to <b>June 22, 1968</b> , that (I) (we) last saw the deceased alive on <b>June 22, 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>Edward W. Ditto, III</b>				22c. DATE SIGNED <b>6-24-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Edward W. Ditto, III, M.D.</b>				22e. ADDRESS <b>217 W. Wash. St., Hagerstown, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/25/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>	
23d. LOCATION (City or Town) (County) (State) <b>Hagerstown-Washington-Md.</b>					
24. FUNERAL DIRECTOR <b>Wm. C. Hone</b>		24a. ADDRESS <b>Rest Haven Funeral Chapel Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>June 26 1968</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

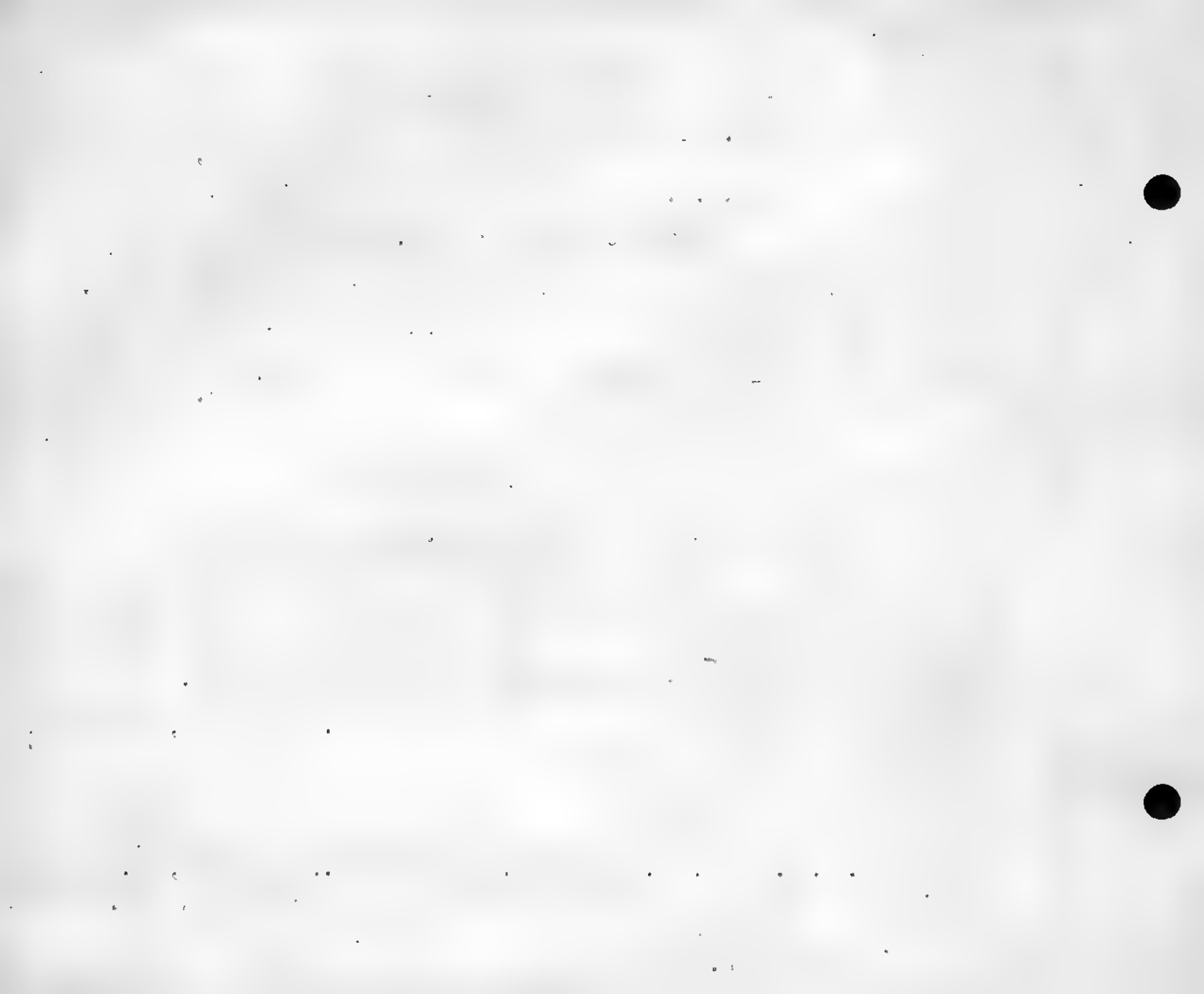


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Pages 1, 2, and 3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First <b>BEARNEDETTA</b>		Middle <b>JOHNSON</b>		Last <b>SPRINGER</b>		2a. DATE KNOWN OF DEATH ESTIMATED <input type="checkbox"/> Month Day Year <b>June 1 19 68</b>	
3. SEX <b>Female</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Feb. 1, 1879</b>		6. AGE (In years) <b>89</b> YRS		2c. DATE PRONOUNCED DEAD Month Day Year <b>June 1, 19 68</b>	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital giving place of death) <b>Washington County Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>House Work</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>1400 Virginia Ave.</b>	
14. FATHER'S NAME First Middle Last <b>Vandell Johnson</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Frances Brasgears</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16b. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Miss Dorothy Springer</b>				ADDRESS <b>1400 Virginia Ave. Hagerstown Md</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Shock from Fractures Following Fall</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Fracture Of Femur And Humerus</b>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10 years</b> <b>11 hours</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7221</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year <b>6 P.M. 5-31- 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Fall while walking in her home.</b>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>Home</b>		21f. LOCATION Street or R.F.D. No City or Town County State <b>1400 Virginia Ave., Hagerstown, Washington, Md.</b>					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <b>Dr. E. W. Ditto, Jr.</b>		EXAMINER'S NAME (Type) <b>Dr. E. W. Ditto, Jr.</b>		22b. DATE SIGNED <b>June 1, 1968</b>		ADDRESS (Street, city, town, or county) <b>215 W. Washington St., Hagerstown, Md.</b>			
23a. BURIAL, CREMATION, or other disposition <b>Buried</b>		23b. DATE <b>6/4/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown, Wash. Maryland</b>			
24. FUNERAL DIRECTOR <b>Funeral Andrew K. Coffman Home Inc./ Hagerstown, Maryland</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>JUN 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH			2b. HOUR
Ada Marie Stottlemeyer						6 Month 30 Day 68 Year			6:20 PM
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS
female		white		11-24-02			65 YRS.		IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH			
W. Va.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			306 S. Locust St.			Inspector		Dress Mfg.	
13a. USJA. RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Md.			Wash.		Hagerstown				306 S. Locust St.
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
First Middle Last					First Middle Last				
John Ashby					Lennie Ashby				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT		Address		
No			220-26-0034		Alice Hurd		Hagerstown, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION									Seconds
4100 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 4201									
(b) HYPERTENSIVE ARTERIOSCLEROTIC C.V. DISEASE									Yrs.
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
Chronic Congestive Heart Failure - Diabetes Mellitus									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County	State
22a. I certify that (I) (this hospital) attended the deceased from <u>March</u> , 19 <u>63</u> , to <u>30 June</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>24 June</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED		
<u>W. N. FENDER</u>					M.D. - DEGREE		1 July 1968		
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
W. N. FENDER					218 N. Potomac St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)		
burial		7-2-68		Evansville Cemetery			Evansville, W. Va.		
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Minnich Funeral Home Hagerstown, Md.					JUL - 8 1968		Charles Judge		





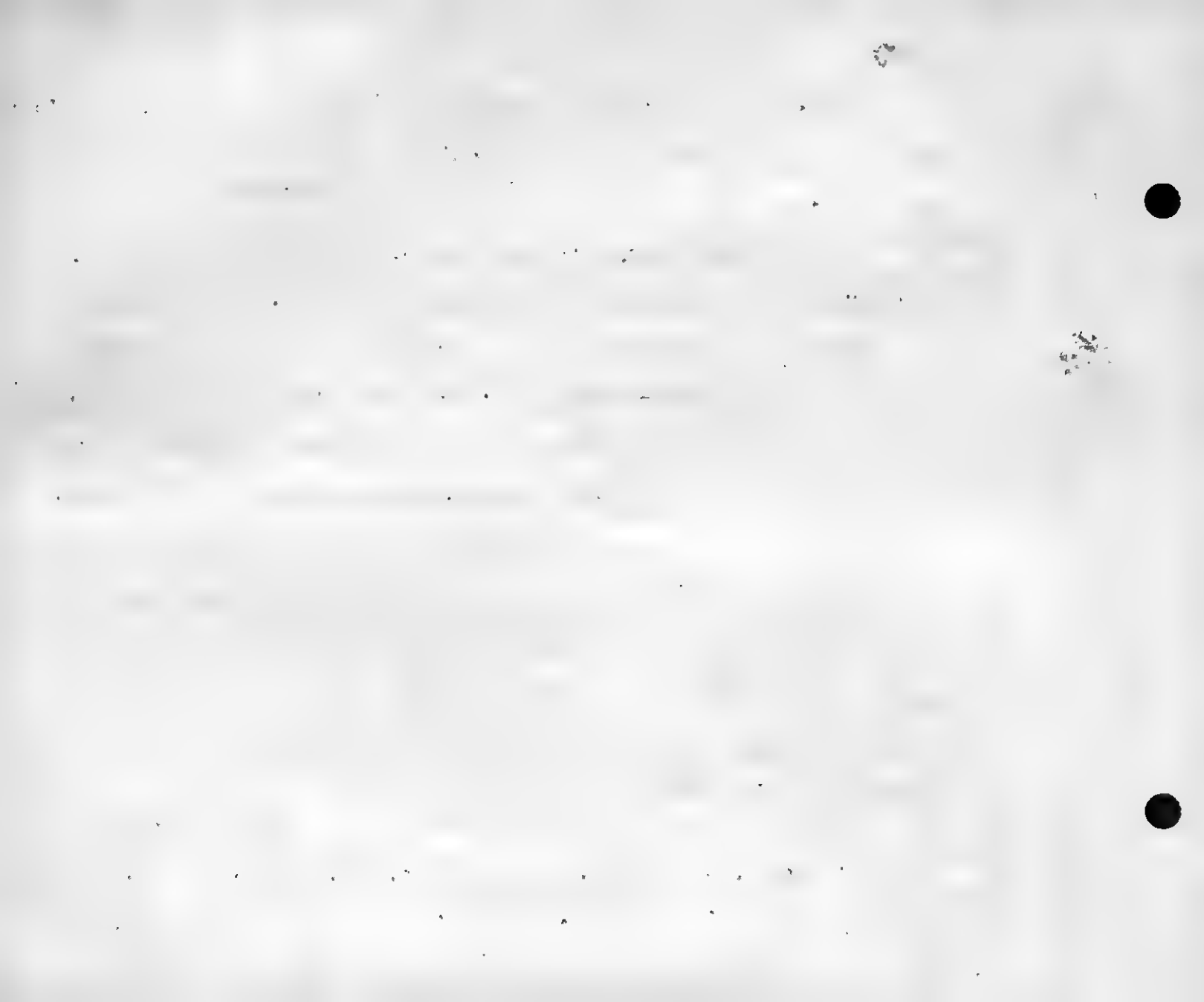
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1

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
Item 15 Film G403 3/20/68  
**CERTIFICATE OF DEATH**

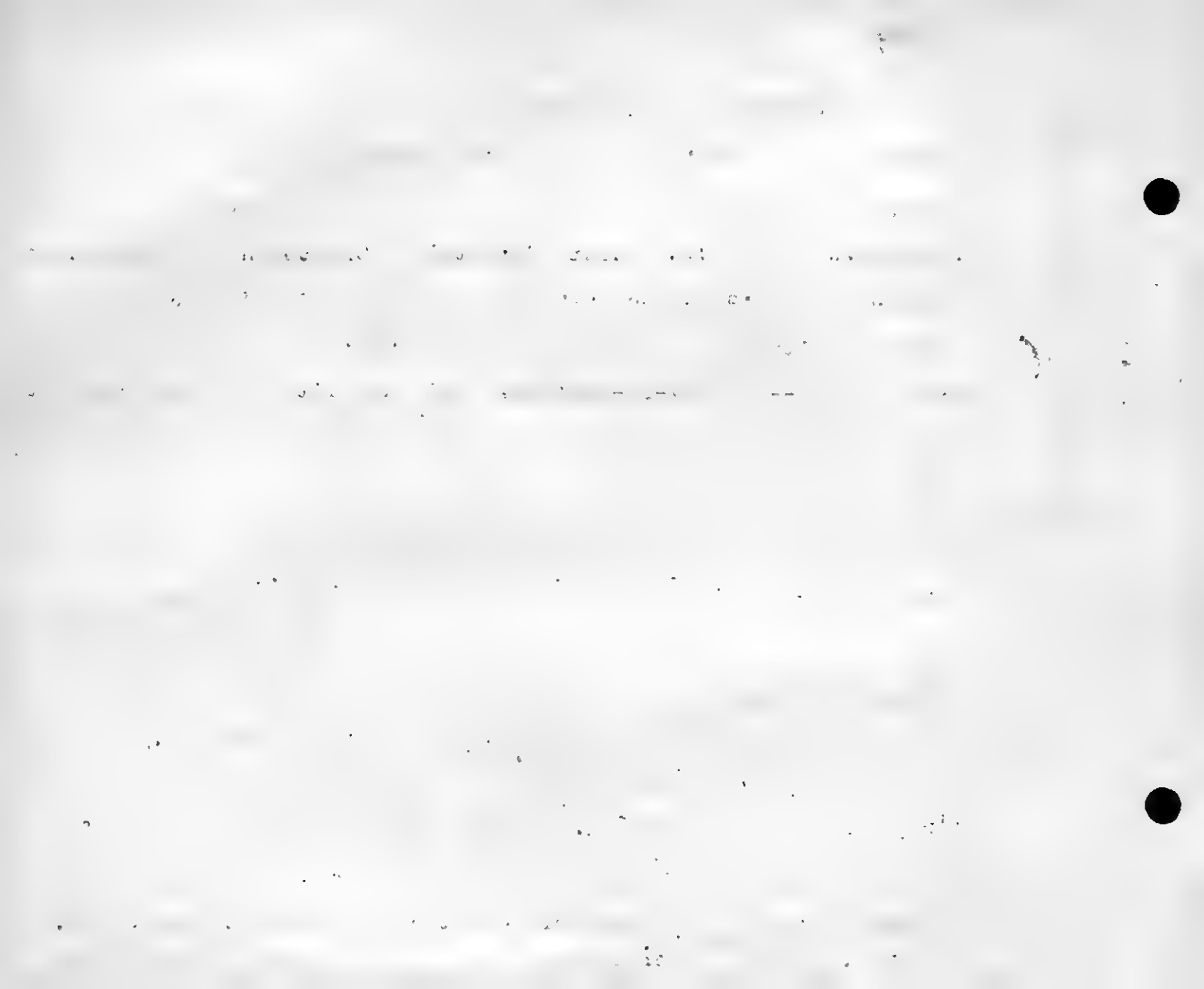
1. DECEASED-NAME (Type or print) <b>James Garfield Testerman</b>			2a. DATE OF DEATH <b>June</b> Month <b>28</b> Day <b>1968</b> Year			2b. HOUR <b>12:01</b>			
3 SEX <b>Male</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>9/10/90</b>		6 AGE (In years lost birthday) <b>77</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>North Carolina</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WASHINGTON</b> Md.			
10 CITY OR TOWN OF DEATH <b>HAGERSTOWN</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>WESTERN MD. STATE HOSPITAL</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>cabinet maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Lumber</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Frederick</b>		13c. CITY OR TOWN <b>Union Bridge</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. 2</b>	
14 FATHER'S NAME <b>Wilson Testerman</b>			15. MOTHER'S MAIDEN NAME <b>Nancy J. Mock Sprague</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown? <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>218-32-9684</b>		17 INFORMANT <b>Mrs. Marshall Testerman</b> Address <b>Union Bridge, Md.</b>					
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>multiple pulmonary emboli with massive/infarction</b> <b>185 X</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of prostate with metastases</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>11/18</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>9 yrs.</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <b>Cerebral vascular accident</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <b>yes</b>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (the hospital) attended the deceased from <b>2/8</b> , 19 <b>68</b> , to <b>6/28</b> , 19 <b>68</b> , that (I) (we) saw the deceased alive on <b>6/27</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b. SIGNATURE <b>Domingo A. Garcia</b>		DEGREE <b>M.D.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>6/28/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>Domingo A. Garcia, M.D.</b>		22e. ADDRESS <b>Western Md. State Hospital 1500 Pa. Ave., Hagerstown, Md.</b>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Removal - burial</b>		23b. DATE <b>6-30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>STERLING CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>STERLING, VIRGINIA</b>			
24. FUNERAL DIRECTOR <b>J.B. Green - Green Funeral Home, Herndon, VA.</b>		ADDRESS		25a. REC'D BY REGISTRAR <b>JUL - 2 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR		
WOODROW WILSON TITUS						June 20 1968			2 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
Male		White		Feb 19 1913		55 YRS.					
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Virginia			USA				Washington Md				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown			Wash County Hospital			Custodian		Ferguson Co			
13a. USUAL RESIDENCE (Where deceased lived, if institution residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. HOME CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Washington		Hagerstown		YES		510 Jefferson St		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last		
Henry L. Titus						Mae Gant					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT					Address	
No			---		217-16-2004		Mrs Marie Ann Titus 510 Jefferson St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 465 X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>7-1-68</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2-3 days</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Chronic alcoholism, Emphysema</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>19 June</u> , 19 <u>68</u> , to <u>20 June</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>19 June</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard T. Binford</u>					22c. DATE SIGNED 21 June 68		22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.				
					22e. ADDRESS 1135 Potomac Avenue Hagerstown, Md.						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		6/24/68		Boonsboro Cemetery		Boonsboro Wash Co Md.					
24. FUNERAL DIRECTOR Hagerstown Md. ADDRESS Andrew K. Coffman Funeral Home Inc					25a. REC'D BY REGISTRAR DATE JUN 26 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				



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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR
Earl Hanks Trueax						6 Month 15 Day 68 Year			10:50 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		IF UNDER 1 YEAR	
male		white		1-27-1893		75 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
Penna.		USA				Washington			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Hagerstown			Wash. County Hospital			Farmer			Farming
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Penna.			Fulton			Crystal Spring			
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Palmer Trueax						Irene Hanks			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			200-28-3231			Velma Trueax			Crystal Spring, Penna.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u>									days.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4 x 10</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Phlebotromboses of Deep leg veins</u>									days.
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Congestive Heart Failure</u>									years.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Pneumonia, Chronic bronchitis &amp; emphysema</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from <u>5-24-68</u> , 19 <u>68</u> , to <u>6-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Charles C. Spencer</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED 6/18/68		
22d. PHYSICIAN'S NAME (Type) Charles C. Spencer, M.D.					22e. ADDRESS 145 S. Prospect St., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
burial		6-18-68		McKendree Cemetery		Fulton Co. Penna.			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
Minnich Funeral Home Hagerstown, Md.							DATE JUN 19 1968		<u>Charles Judge</u>



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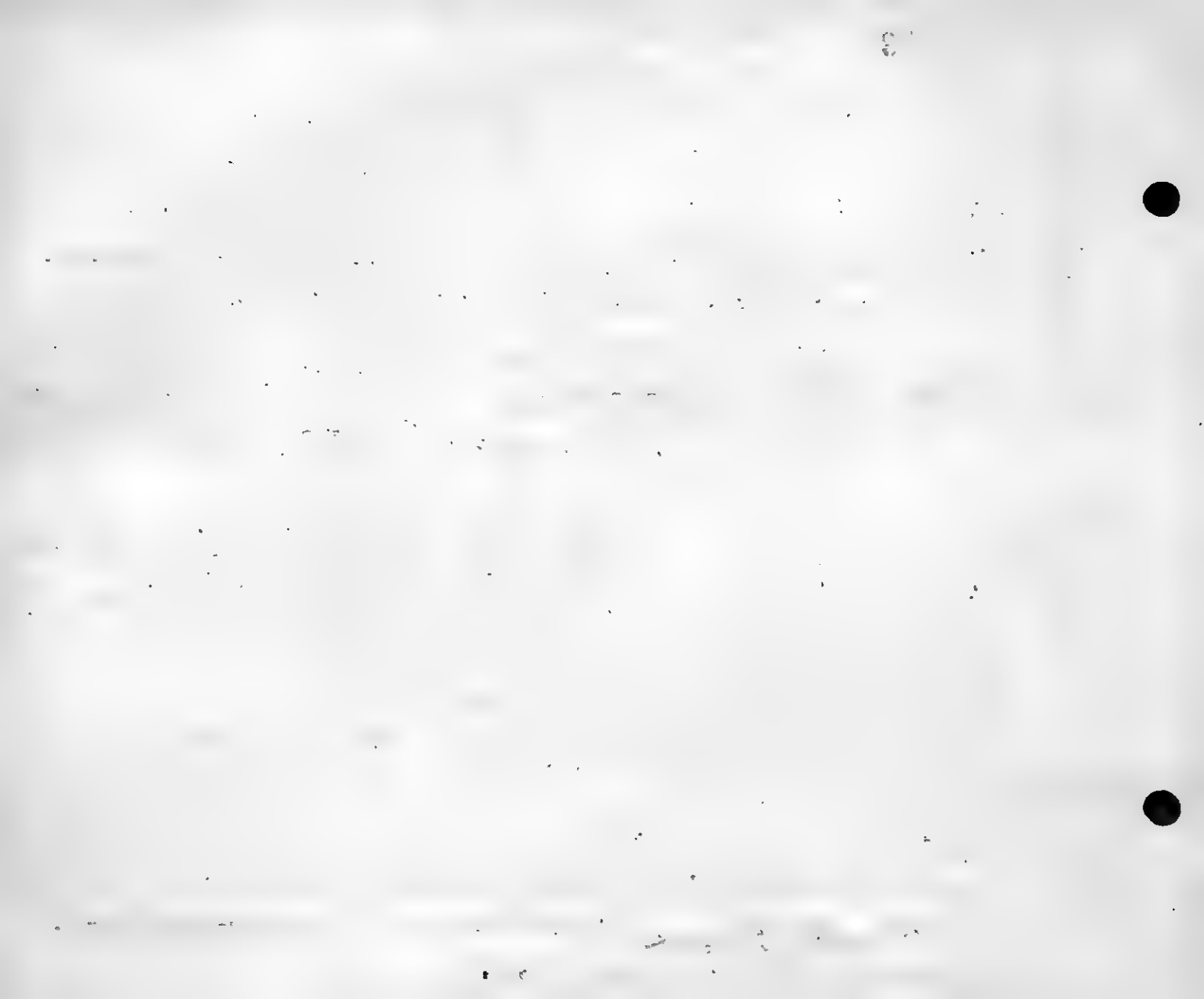
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1

15133

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>Reilly R Ulrich</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>5:20 P.M.</b>	
3. SEX <b>Male</b>		4 RACE <b>White</b>		5 DATE OF BIRTH <b>Feb 2, 1884</b>		6 AGE (In years last birthday) <b>84</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>CO. PA.</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington Co.</b>	
10. CITY OR TOWN OF DEATH <b>Williamsport</b>		11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>Williamsport Sanatorium</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Tool Maker</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Machy. Mfg.</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13e. STREET AND NUMBER <b>1717 Terrace</b>		14 FATHER'S NAME First <b>George</b> Middle <b>Ulrich</b> Last <b>Lucinda</b>		15. MOTHER'S MAIDEN NAME First <b>Field</b> Middle <b>Field</b> Last <b>Field</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>Yes</b>		16b. SOCIAL SECURITY NO. <b>217-18-6292</b>		17 INFORMANT <b>Granddaughter -</b> Address <b>Mrs. A.M. Bacon 1717 Terrace, Hager, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pneumonia, (terminal)</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>stroke</b> (b) <b>ASCVD</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>stroke</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cancer of Rectum; Cancer of Prostate; Anemia; Parkinsonism; glaucoma</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED White <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>11 Jan 1961</b> to <b>date</b> , 19 <b>1968</b> , that (I) (we) last saw the deceased alive on <b>6 June 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death.							
22b. SIGNATURE <b>Richard T. Binford</b>		22c. DATE SIGNED <b>14 June, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>Richard T. Binford, M.D.</b>		22e. ADDRESS <b>1135 Potomac Ave., Hagerstown, Md. 21740</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/15/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown-Washington-Md.</b>	
24. FUNERAL DIRECTOR <b>Wm. C. Horst</b>		24b. ADDRESS <b>Rest Haven Funeral Chapel Hagerstown, Md.</b>		25a. REC'D BY REGISTRAR <b>JUN 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. J. Judge</b>	





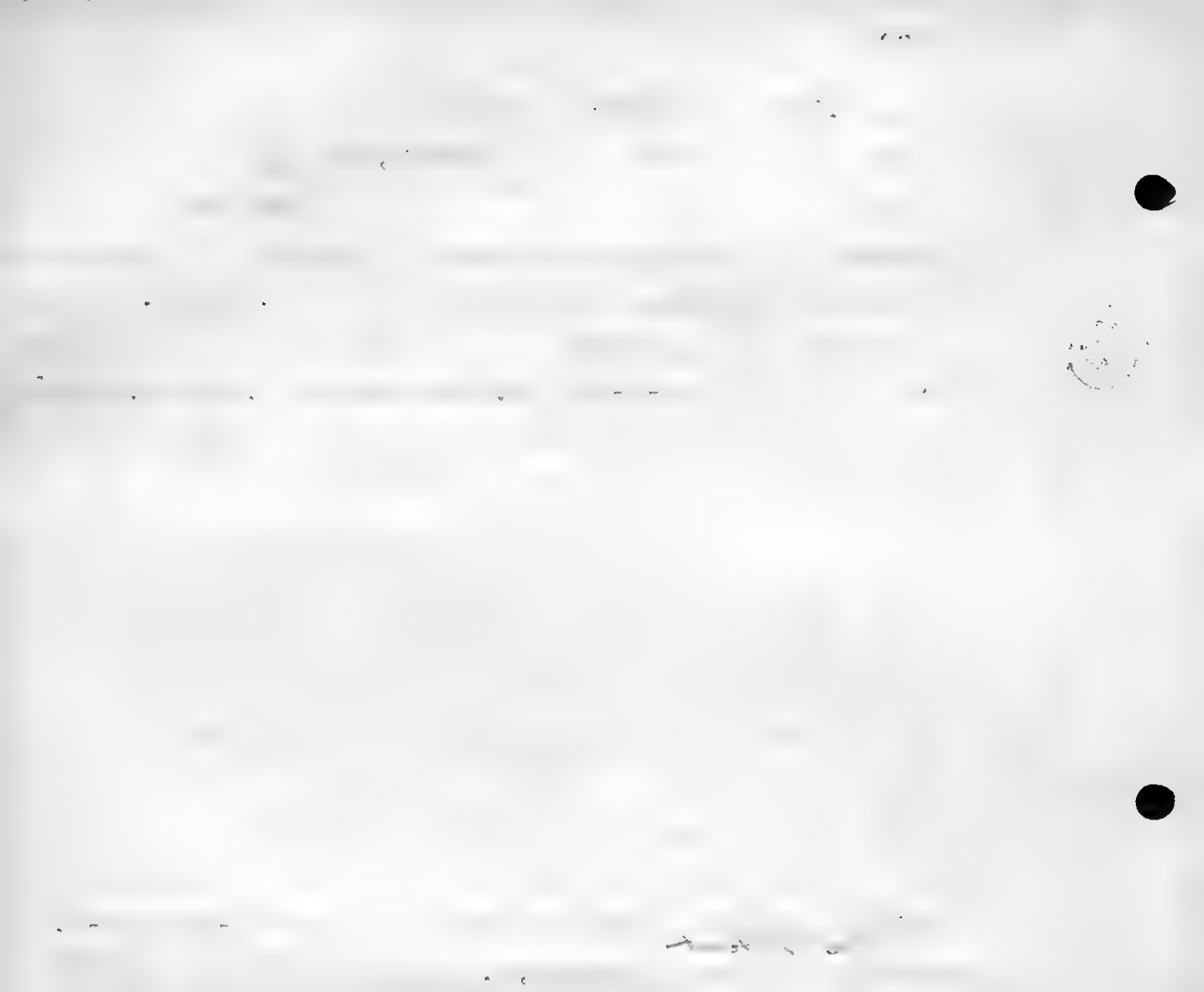
TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13 (1)  
30M REV 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Oliver Dearmont Vincent</b>			2a. DATE OF DEATH Month <b>June</b> Day <b>19</b> Year <b>1968</b>			2b. HOUR M			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>August 30, 1912</b>		6. AGE (In years last birthday) <b>55</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Washington</b> Md.			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>cab driver</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>transportation</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Washington</b>		13c. CITY OR TOWN <b>Hagerstown</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>235 N. Locust St.</b>	
14. FATHER'S NAME First Middle Last <b>Charles Vincent</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Mamie Hilliard</b>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>			
16b. SOCIAL SECURITY NO <b>219-05-2639</b>			17. INFORMANT Address <b>Mrs. Faith Vincent 235 N. Locust St. Hagerstown, Md.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Blood loss - Anemia</b> 7 days 5719 DUE TO, OR AS A CONSEQUENCE OF (b) <b>Esophageal Varices - Rupture</b> 7 days DUE TO, OR AS A CONSEQUENCE OF (c) <b>Cirrhosis of Liver</b> years 5870 PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Hx. gastric ulcer.</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar 19 1968</b> to <b>date</b> 19 <b>June 19 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>Richard T. Binford</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>20 June, 1968</b>			
22d. PHYSICIAN'S NAME (Type) <b>Richard T. Binford, M.D.</b>				22e. ADDRESS <b>1135 Potomac Ave., Hagerstown, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>6/22/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rest Haven Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Hagerstown-Washington-Md.</b>			
24. FUNERAL DIRECTOR <b>Wm. G. Hunt</b> <b>Rest Haven Funeral Chapel Hagerstown, Md.</b>				25a. REC'D BY REGISTRAR DATE <b>JUN 24 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

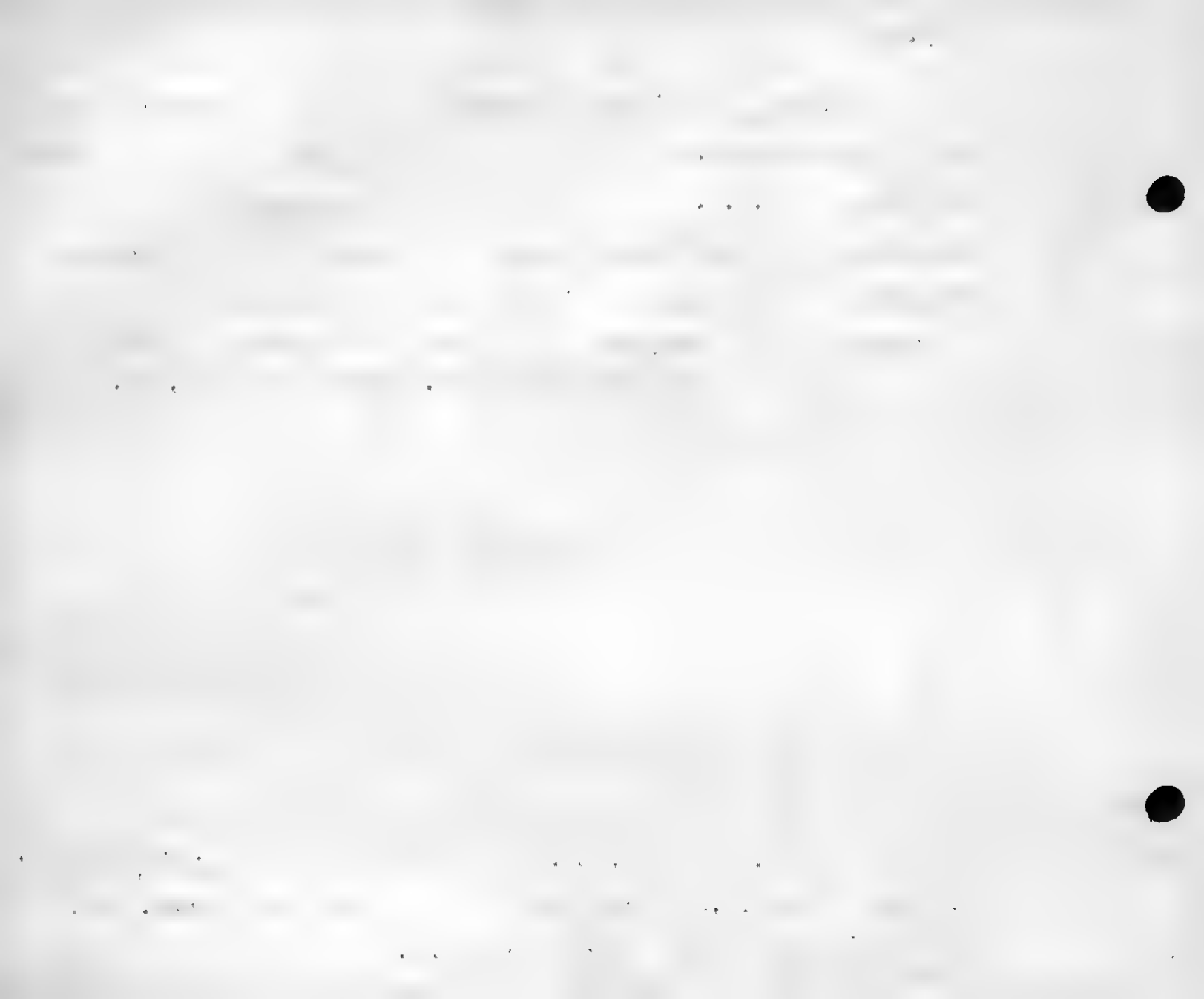


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form RM-3. Page 5 may be retained for your files.

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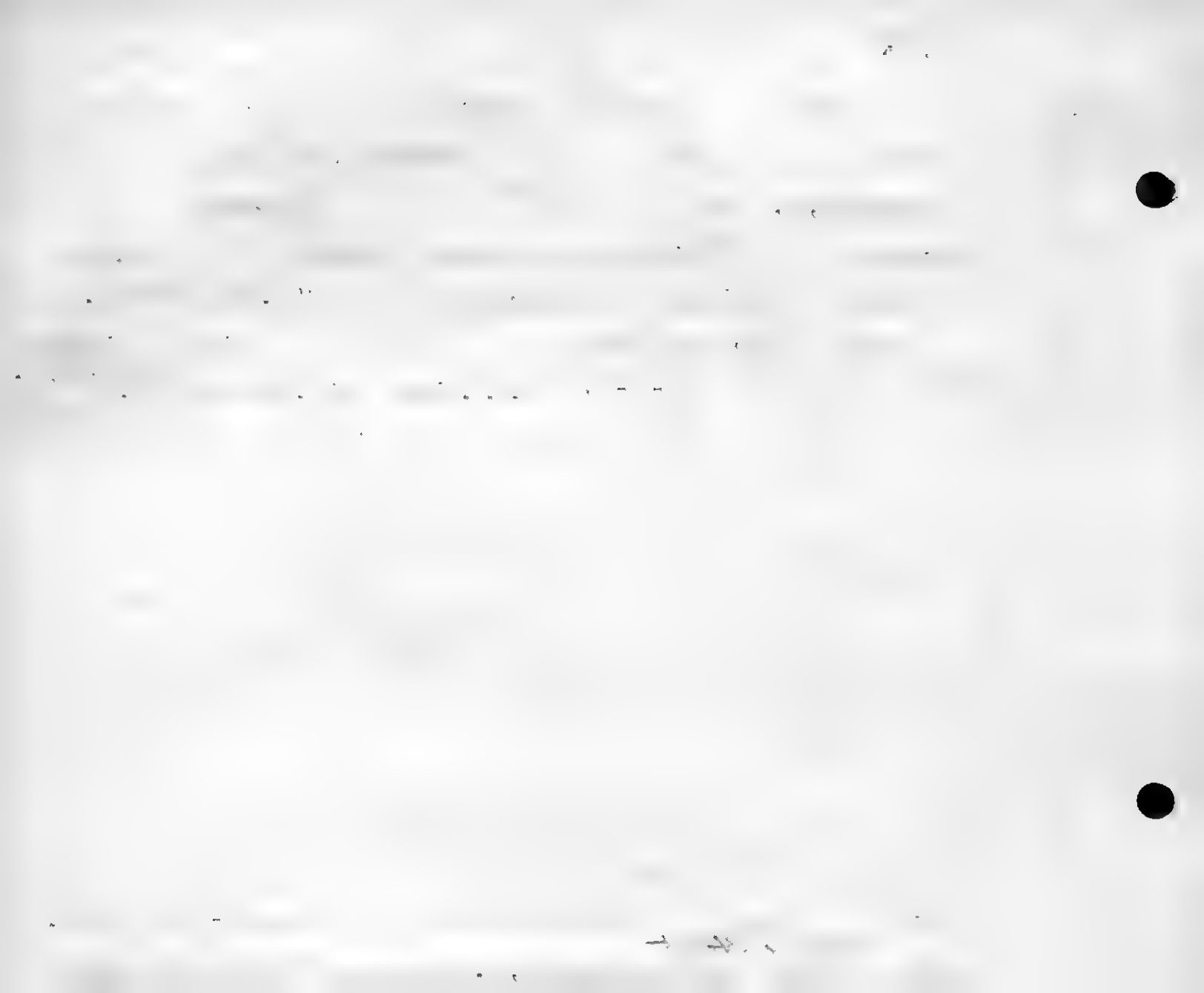
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Keller Edison Weller						Month Day Year			June 10 1968 2A M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			2d. HOUR
Male	White	June 4, 1923	45 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year			June 10 1968 2A M
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		U.S.A.				Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Washington County			Manager			Orchard		
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital give street address)			13b. CITY OR TOWN			13c. INSIDE CITY, M 15?			13e. STREET AND NUMBER		
Maryland			Washington			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			None		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
Russell Weller			Mary Kelley Weller								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO			17. INFORMANT			ADDRESS		
No			220-30-9224			Mary A. Weller			Big Pool, Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u>										1 hr.	
4109 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Arteriosclerotic Heart Disease</u>										5-10 yrs	
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4221											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Edward W. Ditto, III, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6/11/68			
EXAMINER'S NAME (Type)						ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
						DEPUTY MEDICAL EXAMINER <input type="checkbox"/>					
						ADDRESS (Street, city, town, or county)		217 W. Washington St. Hagerstown, Maryland			
23a. BURIAL, CREMATION, or other disposition		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		June 13, 68		Park Head		Big Pool Wash. Md.					
24. FUNERAL DIRECTOR						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Thompson Funeral Home Clear Spring, Md.						JUN 12 1968		Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR M	
Edna				Louise	Wilson	June 26 1968			
3. SEX		4 RACE		5. DATE OF BIRTH		6. AGE (in years last birthday)		7. UNDER 1 YEAR MONTHS DAYS	
Female		White		December 29, 1918		54 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH		Md	
Hagerstown, Md.		USA				Washington			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of work'ng life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Washington County Hospital		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		221 S. Mont Ualla Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Harry				Cleveland	Snook	Julia			Viola Ridenour
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
No			031-01-8218			Mr. E. J. Wilson			Hagerstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE - PNEUMONIA</u>								Hours - 2 days -	
4120 DUE TO, OR AS A CONSEQUENCE OF (b) <u>HYPERTENSIVE Cardio-Vascular Disease</u>								Yes.	
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last. 445X DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Chronic Asthmatic Bronchitis									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>20 June, 1968</u> , to <u>26 June, 1968</u> , that (I) (we) last saw the deceased alive on <u>26 June, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>[Signature]</u> M.D. DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>28 June 1968</u>		
22d. PHYSICIAN'S NAME (Type) <u>Wm. N. FENDER</u>					22e. ADDRESS <u>218 N. Potomac St. Hagerstown, Md.</u>				
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		6/29/68		Cedar Lawn Cemetery		Hagerstown-Washington-Md.			
24. FUNERAL DIRECTOR <u>Wm. C. Host</u> ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>					25a. REC'D BY REG-STRAR <u>JUL - 1 1968</u>		25b. REG-STRAR'S SIGNATURE <u>[Signature]</u>		



FOR STATE  
HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print) First Middle Last <b>Michael W. Wintermoyer</b>						2a. DATE KNOWN OF ESTI-DEATH MATED <input type="checkbox"/> Month Day Year <b>6 15 1968</b>			2b. HOUR <b>7:30 PM</b>			
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 5, 1943</b>		6. AGE (In years last birthday) <b>24 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>6 10</b>		IF UNDER 24 HRS. HOURS MIN. <b>6 15</b>		
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Washington</b>			
10. CITY OR TOWN OF DEATH <b>Hagerstown</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Washington County Hosp.</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Policeman</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Municipal</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Virginia</b>				13b. COUNTY <b>Fairfax</b>		13c. CITY OR TOWN <b>Fairfax City</b>		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER <b>10029 Mosby Woods Dr.</b>		
14. FATHER'S NAME First Middle Last <b>Harold Wintermoyer</b>						15. MOTHER'S MAIDEN NAME First Middle Last <b>Dora Angelo</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>				16b. SOCIAL SECURITY NO. (If yes give year or dates of service)		17. INFORMANT ADDRESS <b>Sharon Crouse Wintermoyer, Paw Paw, W. Va.</b>						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Skull Fracture - Brain Stem In.</b> <b>8192</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <b>Jury and Fracture Neck</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 hrs.</b>												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>8144</b>												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>6-15 1968</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) <b>Motorcycle Accident -</b>						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>State Road</b>				21f. LOCATION Street or R.F.D. No. <b>Rt #9</b>		City or Town <b>Leopold Morgan</b>		State <b>W. Va.</b>		
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>DR. E.W. DITTO, III</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED <b>6-15-68</b>				
EXAMINER'S NAME (Type) <b>217 W. WASHINGTON ST., HAGERSTOWN, MD.</b>				City, town, or county)								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>6/19/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Woodrow Cem.</b>				23d. LOCATION (City or Town) (County) (State) <b>Paw Paw, (Morgan) W. Va.</b>				
24. FUNERAL DIRECTOR <b>Johnson Funeral Homes, Berkeley Springs, W. Va.</b>						ADDRESS		25a. REC'D BY REGISTRAR DATE <b>JUN 18 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Michael J. Jones</b>		

02142

U.S. DEPARTMENT OF JUSTICE  
WASHINGTON, D.C. 20535



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A-514  
30M REV. 1-7-68

09142				DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09148			
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) First Middle Last <u>William Wingert Wolfe</u>				2a. DATE OF DEATH Month Day Year <u>June 26 1968</u>				2b. HOUR M <u></u>			
3. SEX <u>Male</u>		4. RACE <u>White</u>		5. DATE OF BIRTH <u>July 2, 1903</u>		6. AGE (In years last birthday) <u>64</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <u>Funkstown, Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <u>Washington</u> Md.					
10. CITY OR TOWN OF DEATH <u>Hagerstown</u>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Washington County Hospital</u>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <u>Foreman</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Refg. Mfg.</u>					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <u>Maryland</u>		13b. COUNTY <u>Washington</u>		13c. CITY OR TOWN <u>Hagerstown</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <u>527 W. Wilson Blvd.</u>			
14. FATHER'S NAME First Middle Last <u>William David Wolfe</u>				15. MOTHER'S MAIDEN NAME First Middle Last <u>Sadie Blanche Davis</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <u>No</u>		16b. SOCIAL SECURITY NO. <u>214-09-0325</u>		17. INFORMANT <u>Mrs. Laura E. Wolfe</u>				Address <u>Hagerstown, Md.</u> <u>527 W. Wilson Blvd.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>4109</u> IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u> 8 days										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4201</u> <u>None</u>											
19a. DATE OF OPERATION <u>None</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>-</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>-</u>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) <u>None</u>		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <u>None</u> <u>19</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>None</u>							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) <u>None</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>- - - - -</u>							
22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 1962, to <u>June 26</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>June 26</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death.											
22b. SIGNATURE <u>Harold R. Tritch Jr MD</u>				DEGREE <u>MD</u>		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>	
22d. PHYSICIAN'S NAME (Type) <u>Dr. Harold R. Tritch, Jr M.D.</u>				22c. DATE SIGNED <u>6-26-68</u>							
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				23b. DATE <u>6/29/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rest Haven Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Hagerstown-Washington-Md.</u>			
24. FUNERAL DIRECTOR <u>W. A. Hunt</u>				ADDRESS <u>Rest Haven Funeral Chapel Hagerstown, Md.</u>		25a. REC'D BY REGISTRAR <u>JUN 28 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

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